

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: June 27, 2025

Inspection Number: 2025-1384-0003

Inspection Type:
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by its general partners,
Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Brant, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 23-27, 2025.

The following intake was inspected:

- Intake: #00148951 - regarding falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program are complied with.

The licensee has failed to comply with the home's falls prevention and management program by not ensuring that Falling Star Visual Identifiers were in place for a resident. The identifiers were used to help staff recognize residents at high risk of falling.

When brought to the home's attention, the Falling Star identifiers were put in place for the resident.

Sources: Record review, observations and interviews.

Date Remedy Implemented: June 26, 2025.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in a resident's plan of care for falls prevention and management as well as bathing was documented on for a period of two months.

Sources: Record review and interviews.

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident's assessment, required as part of the home's falls prevention program, was documented. The program required Head Injury Routine (HIR) be initiated after any unwitnessed fall and the HIR assessments be completed and recorded on the Head Injury Flow Sheet at specified time intervals. One resident's Head Injury Flow Sheet was missing documentation of a HIR assessment from a required interval.

Sources: Record review.