Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
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Public Report

Report Issue Date: January 30, 2025
Inspection Number: 2025-1318-0001
Inspection Type: Critical Incident
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Wenleigh, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20, 21, 23, 24, 27, 28, 29, 30, 2025

The following intake(s) were inspected:

- Intake: #00127680 - Critical Incident (CI) #2833-000017-24/2833-000018-24 related to prevention of abuse and neglect
- Intake: #00128016 -Critical Incident (CI) #2833-000019-24 -related to prevention of abuse and neglect
- Intake: #00133557 - Critical Incident (CI) #2833-000023-24 -related to fall prevention and management

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
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: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that resident 's plan of care was revised when the resident's skin tear was resolved.

The resident's written plan of care was revised on January 23, 2025.

Sources: Resident 's clinical record, interview with Director of Care (DOC).

Date Remedy Implemented: January 23, 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 (1) (c)

Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for resident, had clear directions to staff related to the sling size.

Resident required lift for transfer but the care plan did not identify the size of the sling used for transfers.

Sources: Resident's care plan and interview with the ADOC and RN.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that hip protectors were applied to resident as specified in their plan of care.

Resident's plan of care indicated that they are at high risk for falls and require hip protectors as a fall prevention intervention.

Sources: Observations of resident, Resident's clinical records; and Interviews with Personal Support Worker (PSW) and Registered Nurse(RN).

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A: The licensee failed to protect resident from physical abuse by another resident.

Ontario Regulation 246/22, section 2, defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")".

On the day of the incident, a resident caused an injury to another resident.

The Director of Care (DOC) acknowledged that resident performed an act of physical abuse, which resulted in injury to the other resident.

Failure to protect the resident from physical abuse by another resident resulted in the injury.

Sources: Both Resident's clinical records, home's incident investigation notes, and interviews with behavioural support staff (BSO) and DOC.

B: The licensee failed to ensure that a resident was protected from physical abuse by another resident.

On the day of the incident, a resident was exhibiting responsive behaviors. They hit another resident with their wheelchair.

Resident sustained injury as a result of this interaction. An interview with Registered Nurse (RN) confirmed that the incident meets the definition of physical abuse.

Sources: Both resident's clinical record; home's investigative notes; CI #2833-000018-24, Interviews with Registered Practical Nurse (RPN), BSO lead and RN.