Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: July 29, 2025

Inspection Number: 2025-1373-0005

Inspection Type:
Critical Incident
Follow up

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 Woodhaven, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 21, 22, 23, 24, 28, 29, 2025
The inspection occurred offsite on the following date(s): July 25, 2025

The following intake(s) were inspected:

- First Follow Up - CO #001 - O. Reg. 246/22 - s. 102 (9) with CDD 2025-07-11
- First Follow Up - CO #002 - O. Reg. 246/22 - s. 102 (8) with CDD 2025-07-11
- An Intake related to neglect of the resident by the staff.
- An Intake related to the fall of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1373-0003 related to O. Reg. 246/22, s. 102 (9)

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Order #001 from Inspection #2025-1373-0003 related to O. Reg. 246/22, s. 102 (8)

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to ensure staff provided Resident with timely incontinence product changes to keep the resident clean, dry, and comfortable. Internal investigation notes and an interview with the home Administrator revealed that staff did not assist the resident for several hours, during which the resident remained soaked and in need of a change of continence products.

Sources: Internal investigation notes, CIR, and interview with the Administrator.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that theresident, who exhibits responsive behaviors with specific intervention in the care plan, received the required supervision. The resident was left unattended by the staff and subsequently fell. Although another staff member was assigned to cover, they were occupied with other duties at the time of the incident.

Sources: Clinical records, CIR, interviews with staffs.

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