Public Report

Report Issue Date: November 24, 2025
Inspection Number: 2025-1427-0005
Inspection Type:
Complaint
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 Westbury, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 14, 17, 18 - 20, 24, 2025

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00158476, CIS #2943-000020-25 was related to an injury sustained by a resident.
- Intake: #00159533, CIS #2943-000021-25 was related to fall prevention and management.
- Intake: #00162438, CIS #2943-000026-25 was related to improper care of a resident.

The following Complaint intake was inspected:
- Intake: #00158390 was a complaint related to an injury sustained by a resident.

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

Resident Care and Support Services
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home's pain management program was not implemented as required to manage a resident's pain following a change in their health status on a specific date.

Sources: Resident's health records, home's pain management program policy and interview with staff members.

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) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

Staff members did not implement the strategies in the resident's care plan to manage their behaviours on a specific date.

Sources: Resident's health care records and interviews with staff members.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents

s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident.

A Critical Incident (CI) Report submitted by the home did not include the staff names as required.

Sources: CI report, home's investigation notes and interviews with staff members.