

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: March 25, 2026

Inspection Number: 2026-1427-0003

Inspection Type:
Complaint

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 Westbury, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 3-6, 9, 11-13, and 23-25, 2026

The inspection occurred offsite on the following date(s): March 16-19, 2026

The following intakes were inspected in this complaint inspection:

-Intake: #00166127 was related to visitor policy.

-Intake: #00166593 was related to multiple care concerns of a resident.

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Continence Care
- Medication Management
- Food, Nutrition and Hydration
- Residents' Rights and Choices
- Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

A resident was not treated with courtesy, respect and dignity. When the resident requested assistance with their care, a Personal Support Worker (PSW) did not respond appropriately.

Sources: Review of a resident's clinical records; and interviews with a PSW, Director of Care (DOC) and other staff.

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) (a)

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,
(a) the planned care for the resident;

A resident was prescribed a specific device and indicated who was responsible for the operation of the device. The written plan of care did not set out the planned care related to instructions for staff to follow.

Sources: Review of a resident's clinical records; and interviews with a Registered Nurse (RN) and DOC.

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

On two identified dates, faxes were sent for specific referrals at the request of a resident and their family member.

Nursing staff did not follow up to check the status of the referrals. As a result, the resident did not receive the specialized service following their initial request.

Sources: Review of a resident's clinical records; and interviews with two RN's and other staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

i) A resident's plan of care indicated to provide specific dietary interventions at mealtimes. The resident was referred to the Registered Dietitian (RD) who assessed them for a related concern. However, they did not collaborate with the attending physician in the development and implementation of the resident's plan of care.

ii) A resident's plan of care indicated to provide specific dietary interventions at mealtimes. A PSW and RN both reported that the resident made dietary requests that required a reassessment by the RD. However, the RN did not collaborate with the RD in the development and implementation of the resident's plan of care.

Sources: Review of a resident's clinical records; interviews with a PSW, RN and RD.

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident was not given an opportunity to participate fully in the development and implementation of the plan of care related to a medication, as some information regarding the treatment was not communicated.

Sources: Review of a resident's clinical records; interviews with the resident, RN, and Physician.

WRITTEN NOTIFICATION: Plan of Care

NC #006 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.

A resident's plan of care indicated a specific intervention at mealtimes; however, this dietary intervention was not implemented on an identified date.

Sources: Observation, review of a resident's clinical records; interviews with a PSW and RD.

WRITTEN NOTIFICATION: Dress

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 44

Dress

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

A record showed that a resident's skin condition changed due to specific clothing, as acknowledged by the DOC.

Sources: Review of a resident's clinical records; picture record, and interview with the DOC.

WRITTEN NOTIFICATION: Communication Methods

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 47

Communication methods

s. 47. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

Specific communication strategies were not developed or implemented to meet the resident's identified communication needs.

Sources: Review of a resident's clinical records; and interview with a RN and DOC.

WRITTEN NOTIFICATION: Menu Planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (6)

Menu planning

s. 77 (6) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 246/22, s. 390 (1).

A resident's plan of care indicated to provide specific dietary interventions at mealtimes. An individualized menu was not developed or implemented to meet the dietary needs of

the resident.

Sources: Observation, review of a resident 's clinical records; interviews with a PSW and RD.



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**

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002