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

Toronto District
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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: December 4, 2024

Inspection Number: 2024-1427-0005

Inspection Type:
Complaint
Critical Incident
Follow up
Director Order Follow Up (DOFU)

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 12 - 15, 18 - 20, 25, 27 and 28, 2024.

The following Critical Inspection System (CIS) intakes were inspected:

- Intake: #00129241, CIS #2943-000015-24 related to fall prevention and management.
- Intake: #00125137, CIS #2943-000013-24 and Intake: #00129818, CIS #2943-000017-24 related to prevention of abuse and neglect of residents.

The following CIS intake was completed:

- Intake: #00120530, CIS #2943-000012-24 related to fall prevention and management.

The following Complaint intake was inspected:

- Intake: #00120547 related to improper care of residents.

The following Follow-up intakes were inspected:

- Intake: #00118668 related to follow-up of Compliance Order (CO) #001 from inspection #2024-1427-0002

- Intake: #00118669 related to follow-up of CO #002 from inspection #2024-1427-0002
- Intake: #00123459 related to follow-up of CO #001 from inspection #2024-1427-0003
- Intake: #00123457 related to follow-up of CO #002 from inspection #2024-1427-0003
- Intake: #00128327 related to follow-up of Director's Order #001

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1427-0002 related to FLTCA, 2021, s. 6 (7)
Order #002 from Inspection #2024-1427-0002 related to O. Reg. 246/22, s. 40
Order #002 from Inspection #2024-1427-0003 related to O. Reg. 246/22, s. 24 (4)
Order #001 from Inspection #2024-1427-0003 related to O. Reg. 246/22, s. 24 (2) 2.
Director Order #001 related to O. Reg. 246/22, s. 96 (2) (c).

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 a resident received the level of assistance as specified in their plan of care for their care.

Rationale and Summary:

The resident's written plan of care required two-person assistance for care tasks.

A PSW acknowledged that they provided care to the resident without assistance from other staff members. The DOC verified that the plan of care was not followed when required level of assistance was not provided during care.

Failure to provide required assistance for care increased the resident's risk of sustaining an injury and impacted the quality of care.

Sources: The resident's health records, CIS report, interviews with staff members.

WRITTEN NOTIFICATION: Menu planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that the planned menu items were available for a resident's meal.

Rationale and Summary:

The resident was at high nutritional risk. The resident preferred to eat a specific food for a meal and often refused to eat it if it was not available.

The resident's plan of care required the resident to receive the specific food item which was included in the menu for the resident.

A registered staff member and the Food and Nutrition Manager (FNM) acknowledged that the food item was not available to serve for resident's meals on specified dates.

Failure to provide planned menu items increased the resident's nutritional risk.

Sources: The resident's health records, interviews with staff members.