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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Public Report

Report Issue Date: March 12, 2025
Inspection Number: 2025-1427-0002
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 Westbury, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 5-7, 10-12, 2025.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake CI #00136462 - related to prevention of abuse and neglect
- Intake CI #00138913 - 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

WRITTEN NOTIFICATION: Duty to Protect

NC #001 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.

The licensee has failed to ensure that a resident was not neglected by Personal Support Workers (PSWs) and a Registered Practical Nurse (RPN) during a night shift when they did not perform routine safety checks.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

A resident had an unwitnessed fall during a night shift. The home's camera footage revealed that the resident was not routinely checked by staff prior to the fall incident.

The home's resident safety rounds policy stated that staff are to complete safety rounds routinely during their shift. The Assistant Director of Care (ADOC) confirmed that routine safety rounds were to be completed approximately every hour and staff were expected to complete rounds on all residents, unless specified in their care plan.

Sources: The home's investigation notes, the home's resident safety rounds policy; and interview with the ADOC.