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**
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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# Public Report

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| **Report Issue Date:** June 20, 2025 |
| **Inspection Number:** 2025-1427-0003 |
| **Inspection Type:**<br>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): June 11 - 13, 16 - 19, 2025
The inspection occurred offsite on the following date(s): June 13, 2025
The following intake(s) were inspected:

- Intake: #00144032 Critical incident (CI) #2943-000008-25; Intake #00146607 CI #2943-000010-25 related to communicable diseases.
- Intake: #00146863 CI #2943-000011-25 related to fall with injury.
- Intake: #00147566 CI #2943-000013-25 related to alleged staff to resident abuse.

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: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)**
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, residents symptoms indicating the presence of infection were monitored.

i. A resident was indicated on the home's outbreak line list as a confirmed case of COVID-19, and was on additional precautions. The required monitoring for symptoms of infection was not completed on five different shifts.

**Sources:** A resident's clinical records; and interview with the Infection Prevention and Control (IPAC) Lead.

ii. A resident was indicated on the home's outbreak line list as a confirmed case of Influenza A, and was on additional precautions. The required monitoring for symptoms of infection was not completed on five different shifts.

**Sources:** A resident's clinical records; and interview with IPAC lead.