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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 19, 2026
Inspection Number: 2026-1373-0001
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 Woodhaven, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10 - 13, 17, 19, 2026.

The inspection occurred offsite on the following date(s): February 18, 2026.

The following intake(s) were inspected:
An intake and a Critical Incident (CI) were related to an allegation of staff-to-resident abuse.

Two intakes and CIs were related to allegations of residents neglect.

An intake and a CI were related to a complaint of resident safety.

An intake and a CI were related to an allegation of resident-to-resident abuse.

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

Continence Care
Resident Care and Support Services
Responsive Behaviours
Prevention of Abuse and Neglect

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 (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.

The resident had developed infectious symptoms. Days later, the home was informed of the causative agent that caused the infection. However, such information was not communicated to the resident's Power of Attorney for Personal Care that day.

Sources: the resident's electronic health records, home's internal investigative notes, and interview with an Assistant Director of Care (ADRC).

WRITTEN NOTIFICATION: Continence care and bowel management.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

On an identified date, the resident received a type of care provided by one staff member without the assistance of another staff that was required as per the resident's plan of care.

Sources: the resident's electronic health records, home's internal investigative notes, and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

On an identified shift, the staff did not assist the resident with incontinence product changes as per their plan of care.

Sources: the Critical Incident Report (CIR), the resident's health records, the home's internal investigation notes, and interview with the DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

An intervention was initiated for a resident after an altercation. However, such intervention was not reflected in the resident’s written care plan until a later date.

Sources: the resident's health records, and interview with the DOC.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

An intervention was initiated for the resident after an altercation. However, such intervention was not implemented on an identified date and resulted in another resident-to-resident altercation.

Sources: the CIR, the resident's health records, and interviews with the Registered Practical Nurse (RPN) and DOC.

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