

Ministry of Long-Term Care

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

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: October 16, 2025

Inspection Number: 2025-1318-0005

Inspection Type:

Critical Incident

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 Wenleigh, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2, 3, 6-10, 14, 16, 2025.

The following intake(s) were inspected:

-Intake #00155012 - Critical Incident (CI) 2833-000020-25 - Related to responsive behaviour;

-Intake: #00155803 - CI 2833-000021-25 - Related to falls prevention and management;

-Intake: #00156841 - CI 2833-000023-25 - Related to prevention of abuse and neglect;

-Intake: #00158633 - CI 2833-000024-25 - Related to safe and secure home.

Ministry of Long-Term Care

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

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

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

Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care

s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it. Specifically, a registered staff member completed an assessment in a certain month, which recommended a falls prevention measure. This recommendation was not incorporated into the resident's care plan or point of care (POC), which is where care staff access information about a resident's care needs.

Sources: Resident's clinical records and staff interviews.