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: March 25, 2025

Inspection Number: 2025-1373-0002

Inspection Type:
Complaint
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): March 12-14, March 17-21, and March 24-25, 2025
The inspection occurred offsite on the following date(s): March 20, 2025

The following intake(s) were inspected:
• An intake related to a disease outbreak
• An intake related to a complaint regarding the responsive behaviours of a resident
• An intake related to the injury of a resident
• An intake related to the neglect of two residents by staff

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

The licensee has failed to ensure that the resident's rights to live in a safe environment are respected. A review of the home's investigation notes and interview with the Administrator confirmed on a specific day, the staff assigned to one to one (1:1) monitoring for the resident, left the resident unattended for some time to join a gathering in the home which put co-residents at risk of harm. The resident went to another resident's room and approached unexpectedly, causing discomfort and fear related to the resident.

Sources: Resident's Progress notes, Investigation Notes, and Interviews with the resident, Behavioural Supports Ontario (BSO) Lead and Administrator

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure the staff used safe positioning devices and techniques for the resident. The Physiotherapist (PT) indicated that the resident had no strength in their lower extremity due to their medical condition. The resident's care plan and an interview with the Occupational Therapist (OT) indicated that staff had to use safe positioning intervention on the resident's assistive device. The resident confirmed that on the date of the incident, staff had not put the safe positioning intervention on their assistive device.

Sources: CIR, resident's clinical records, and interviews with the resident, PT, OT, and Director of Care (DOC).

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that the registered staff completed the resident's weekly skin reassessment for their identified altered skin integrity. The resident had altered skin integrity and a review of the resident's clinical records and interviews

with registered staff and DOC confirmed that the registered staff had not completed the weekly skin assessment on a specific date.

Sources: Skin and Wound Assessments for the resident and interviews with registered staff and DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that the resident was assessed by a Registered Dietitian (RD) when the resident exhibited a new altered skin integrity. A review of the resident's clinical records and interviews with the RD and DOC confirmed that the registered staff did not complete a dietary referral to the RD related to new altered skin integrity identified on specific dates.

Sources: Resident's Clinical assessment record, LTCH's Policy for Dietary Referral, and interviews with RD and DOC

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 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;

The licensee failed to provide staff assistance to the resident in managing and maintaining continence independently.

The resident's care plan indicated that they required staff assistance with continence care due to their medical condition. A review of the home's internal investigation notes and interview with DOC indicated that the staff did not assist the resident with continence care as indicated in the resident's care plan.

Sources: Internal investigation notes, Staff interviews by DOC, CIR, and interviews with the DOC.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 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

The licensee failed to ensure the staff provided the resident with sufficient

incontinence products to remain clean, dry, and comfortable. A review of the home's internal investigation notes and interview with DOC indicated that the staff did not assist the residents with incontinence product changes during the morning and evening shifts.

Sources: Internal investigation notes, CIR, and interview with the DOC.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #007 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

The licensee has failed to ensure that interventions are in place for the resident. A review of the home's investigation note and interview with the Administrator confirmed on a specific date, the staff, assigned as a 1:1 monitor for the resident, left the resident unattended for some time to join a gathering in the home, which resulted in the resident wandering to the co-residents room.

Sources: Investigation Notes, and interviews with staff, BSO Lead and Administrator.

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