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
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Original Public Report

Report Issue Date: April 04, 2024	
Inspection Number: 2024-1139-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Aurora, Aurora	
Lead Inspector Fatemeh Heydarimoghari (742649)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20, 22, 26, 27, 28, 2024

The following intake(s) were inspected:
- One Intake related to responsive behaviors and laundry.
- One Intake related to alleged abuse.
- One Intake related to Improper treatment
- One Intake related to fall

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

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) 1.

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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes their inherent dignity, worth, and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, or disability.

A Critical Incident Report (CIR) was submitted to the Director for a complaint regarding an incident of alleged abuse during care. As documented in the CIR, the Personal Support Worker (PSW) was providing care for the residents and had inappropriate behaviour.

The home's internal investigation notes indicated that the resident acknowledged laughing at the moment but felt threatened and disrespected.

The PSW confirmed the incident happened during a care interaction. The Assistant Director of Care (ADOC) also acknowledged that the PSW's behaviour was inappropriate and crossed the boundary of professionalism.

Failure to treat the resident with courtesy and respect put the resident at risk of emotional harm.

Sources:
CIR, home investigation notes, and interviews with staff. [742649]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff, or

A CIR was submitted to the Director related to a written complaint concerning the care of a resident.

The long-term care home received a complaint indicating a concern regarding a resident contracting a pathogen from a coresident

A review of the resident progress notes and provided documents from the home demonstrated that there was no documentation that the home investigated the incident and, as a result, did not take any action.

The Administrator and Director of Care acknowledged that the home received a complaint concern from the resident's SDM regarding a co-resident with an infectious symptoms in the dining room and resident's bathroom. However, the home did not investigate the incident as they believed the chance of getting the infection from a co-resident was very low.

Failure to investigate the incident posed a risk of not identifying potential harm and not implementing interventions for the resident's health and safety.

Sources:
CIR, interview with DOC and Administrator. [742649]