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

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Original Public Report

Report Issue Date: July 25, 2024

Inspection Number: 2024-1139-0003

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20, 21, 24 -28, 2024 and July 3-5, and July 8-10, 2024

The following intake(s) were inspected:
- Intake related to improper care of a resident
- Intake related to an outbreak
- Four intakes related to staff to resident abuse and neglect
- Intake related to retaliation, abuse neglect, continence care and skin and wound

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: INTEGRATION OF ASSESSMENT, CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff collaborated with each other in the implementation of a resident's plan of care when they were assessed for specific exhibited symptoms.

Rationale and Summary

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report (CIR) related to an outbreak.

Documentation in the clinical health records for a resident indicated the resident was assessed by the Nurse Practitioner (NP) on a specified date. The resident had completed a specific treatment then commenced an additional treatment on specific dates.

On a specified date, the NP assessed the resident and documented that the resident had ongoing symptoms, their treatment plan for the resident was identified for

specific treatment for seven days, and an additional specific treatment as needed for seven days with monitoring of the resident's condition during the treatments for five days.

The NP stated they did not recall collaborating with the Registered Practical Nurse (RPN) after their assessment of the resident. The RPN stated when the NP or MD gives a medical order they repeat back the order to confirm it is correct and did not recall the NP discussing the resident's treatment plan. Also, if the NP had given a specific medical order for monitoring of the resident they would have included this directive in the telephone order when it was received on a specified date.

The Administrator acknowledged that staff failed to collaborate in the implementation of the resident's treatment plan.

Failure of the NP and registered nursing staff to collaborate in a resident's planned care related to treatment monitoring contributed to the nursing staff from implementing the NP's plan of monitoring the resident's treatment and potential worsening of their medical status.

Sources: Resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in their plan.

Rationale and Summary
A CIR was submitted to the Director related to a fall incident from a resident's bed during care that resulting in an injury.

The resident's plan of care at the time of the incident indicated the resident was at risk for falls therefore was a two person total assistance with all aspects of personal hygiene and bed mobility. The Registered Nurse (RN) and the Assistant Director of Care (ADOC) indicated the same. The Personal support (PSW) was unavailable for interview during the inspection. The ADOC further clarified through the home's investigation of the incident, the PSW had stated they had provided care to the resident on their own without assistance.

The ADOC and the Administrator confirmed the resident did not receive care as was specified in their plan of care resulting in an injury to the resident.

By not ensuring the resident received care as was specified in their plan resulted in an injury to the resident.

Sources: CIR, homes' investigation notes, PSW statement, resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1. The licensee has failed to immediately report an alleged abuse to the Director involving a resident.

Rationale and Summary
A complaint was made to the Director on a specified date by a substitute decision maker (SDM) related to an alleged abuse to a resident. A CIR was submitted to the Director related to the same issue for the same resident on a specified date.

The resident's clinical records indicated that on a specified date the SDM verbally reported to the RN an alleged abuse related to the resident. The SDM had notified the resident home area (RHA), had spoken with the RN stating the resident's concern and alleging abuse. The Administrator who had indicated that they had become aware two days later of the alleged abuse had commenced an investigation into the concern.

The home's "Reporting Certain Matters" policy stated that any staff member having knowledge of a reportable incident must immediately report the information to their immediate supervisor or the staff member in charge of the home. The person receiving the report must ensure safety of the residents and staff in the home. Once safety has been obtained the Administrator, Director of Care or designate must then report the occurrence and related information about the occurrence to the reporting authority following set guidelines for reporting.

The Administrator identified that the RN should have reported the incident immediately to the on call manager. Also, the on-call manager would provide direction regarding reporting to the Ministry of Long Term Care (MLTC) if required. The Administrator acknowledged that this incident was reported to the MLTC two days after the incident date, as the incident was not reported to management immediately.

Failure to notify the Director of an incident within the required period of time did not pose a risk to the resident's care or safety.

Sources: CIR, resident's clinical records; the home's investigation notes, the home's reporting policy, interviews with staff.

2. The licensee has failed to immediately report an alleged abuse to the Director involving a resident.

Rationale and Summary
A CIR was submitted to the Director on a specified date related to an alleged abuse incident involving a PSW and a resident.

The home's investigation notes indicated the Social Worker (SW) had notified the former Director of Care (DOC) on a specified date of the alleged abuse incident. Interview with SW confirmed that the former DOC was informed of the interaction between the PSW and the resident on the same day.

The home's "Reporting Certain Matters" policy stated that any staff member having knowledge of a reportable incident must immediately report the information to their immediate supervisor or the staff member in charge of the home. The person receiving the report must ensure safety of the residents and staff in the home. Once

safety has been obtained the Administrator, Director of Care or designate must then report the occurrence and related information about the occurrence to the reporting authority following set guidelines for reporting.

The Administrator acknowledged and confirmed the allegation of abuse incident was not immediately reported to the Ministry until one day later.

Failure to notify the Director of an incident within the required period of time did not pose a risk to the resident's care or safety.

Sources: CIR, the home's investigation notes, the home's reporting policy, interviews with staff.

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) (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 a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident with altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A complaint was submitted to the Director regarding an alleged abuse of a resident.

The resident's clinical health records that were completed indicated there was an identified alteration on the resident's skin to specific areas of the resident's body on a specified date. Also, the resident's clinical records from a specific two week period in the same month, revealed that a weekly skin assessment was not completed for the identified skin issue.

Interviews with the RPN and the home's previous Skin and Wound Lead (SWL) confirmed that the resident's weekly skin assessment was not completed in the aforementioned time period.

The home's skin and wound program policy directs registered staff to complete a skin reassessment weekly until healed.

Failure to complete a weekly skin assessment might have prevented the staff from monitoring the progression of the resident's skin issue posing a risk for further altered skin integrity.

Sources: Resident's clinical health records, home's skin and wound program policy, interviews with staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 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
In accordance with the IPAC Standard for Long Term Care Homes April 2022, revised September 2023, section 3.1 (b) directs the licensee to ensure that surveillance is performed on every shift to identify cases of healthcare acquired infections (HAIs), device-associated infections and Antibiotic Resistant Organisms (AROs).

The licensee has failed to ensure that a resident's infectious symptoms were recorded on every shift.

Rationale and Summary
A Critical Incident Report (CIR) was submitted to the Director related to an outbreak.

A resident's electronic health records indicated that they were identified with specific symptoms on a specified date and with a specified medical diagnosis three days later.

The resident received medical treatment for the specified medical diagnosis. The resident had completed a specified treatment on a specified date then commenced an additional treatment that same day and completed the treatment on a specified date. A further review of the resident's electronic clinical notes reflected a lack of documentation of the resident's symptoms on multiple shifts and on their completion of their medical treatments on two specified dates.

The RPN acknowledged that on a specified date they did not document on resident's medical condition when the resident received their last treatment.

The Infection Prevention and Control Lead (IPAC) and the Administrator confirmed that staff were expected to document on the residents including their infectious

symptoms every shift in their electronic clinical records until their symptoms were resolved.

Failure to record the resident's symptoms every shift might have hindered the staff from monitoring the resident's treatment status.

Sources: Resident's electronic health records; CIR, IPAC documents, interviews with staff.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;

The licensee failed to ensure that a documented record was kept in the home that includes, the nature of a verbal complaint reported by a resident's SDM.

Rationale and Summary
A complaint was made to the Director on a specified date by a substitute decision maker (SDM) related to an alleged abuse to a resident. A CIR was submitted to the Director related to the same issue for the same resident on a specified date.

The resident's clinical records indicated that on a specified date the SDM verbally reported to the RN an alleged abuse related to the resident. The SDM had notified the resident home area (RHA), had spoken with the RN stating the resident's concern and alleging abuse. The Administrator who had indicated that they had

become aware two days later of the alleged abuse had commenced an investigation into the concern.

Review of the home's complaints and critical incident tracking logs did not indicate the SDM's verbal complaint was logged by the Administrator.

The home's policy LTC Community Administration, Risk Management "Complaints" policy indicated there is a formal tracking of complaints using the Complaint Workbook in the Home with quarterly review and analysis.
Indicated under Procedures for Verbal Complaints:
1. The individual receiving a verbal complaint will deal with the concern if it is within their abilities. All verbal complaints should be reported to the department manager for tracking and trending.
6. Verbal complaints that cannot be resolved within 24 hours after receipt will be:
ii. Logged in the home's Complaint Log Workbook

The Administrator confirmed the verbal complaint by the resident's SDM was not logged in the home's digital complaint log because it was a verbal complaint, this process was completed for written complaints.

In failing to include the SDM's verbal complaint in the home's complaint log, the concern related to the resident remained untracked for the home's monthly trending analysis.

Sources: CIR, Policy 100-LTC Community Administration, Risk Management "Complaints", email communication, home's complaint log, interview with staff.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (5) (b)
Dealing with complaints
s. 108 (5) Where a licensee is required to immediately forward a complaint under clause 26 (1) (c) of the Act, it shall forward it in a form and manner acceptable to the Director, and,
(b) outside normal business hours, using the Ministry's after hours emergency contact method.

The licensee failed to immediately forward a complaint under clause 26 (1) (c) of the Act, in a form and manner acceptable to the Director outside normal business hours, using the Ministry's after hours emergency contact method on a specified date.

Rationale and Summary
A complaint was made to the Director on a specified date by a substitute decision maker (SDM) related to an alleged abuse to a resident. A CIR was submitted to the Director related to the same issue for the same resident on a specified date.

The resident's clinical records indicated that on a specified date the SDM verbally reported to the RN an alleged abuse related to the resident. The SDM had notified the resident home area (RHA), had spoken with the RN stating the resident's concern and alleging abuse. The Administrator who had indicated that they had become aware two days later of the alleged abuse had commenced an investigation into the concern.

The Administrator confirmed that the CIR was not immediately reported to the Director using the Ministry's after hours emergency contact method on a specified date.

By not immediately reporting allegations of staff to resident abuse, places the

residents at risk for ongoing situations of alleged abuse.

Sources: CIR, resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 27 (2) OF ACT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that critical incident system report (CIR) made to the Director included a description of the individuals involved in the incident, including, the names of any staff members or other persons who were present specifically three identified staff.

Rationale and Summary
A CIR was submitted to the Director on a specified date related to an allegation of abuse and neglect incident involving a resident and staff members. The home's investigation notes identified three staff involved in the CIR. The CIR did not include the names of the staff members or other persons who were present.

The Administrator confirmed that this report did not include the above-mentioned

information.

Failure to include staff names in the CIS reports may affect identifying trends with staff members within the home.

Sources: CIR, home's investigation notes, interview with staff.

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 27 (2) of Act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 4. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

1. The licensee failed to ensure that reports made to the Director included the analysis and outcome of the home's investigation, involving a resident.

Rationale and Summary
A CIR was submitted to the Director on a specified date related to an alleged incident of abuse towards a resident by a staff member. The CIR did not include the long term care home's (LTCH) analysis and outcome of the investigation of the incident.

The Administrator confirmed that this report did not include the above-mentioned

information.

Failure to include analysis and outcome of the home's investigation in CIS reports may affect identifying trends within the home.

Sources: CIR, home's investigation notes and interview staff.

2. The licensee failed to ensure that critical incident system reports (CIR) made to the Director included the analysis and outcome of the home's investigation, involving a PSW and a resident.

Rationale and Summary
A CIR was submitted to the Director on a specified date related to an allegation of improper treatment incident involving a resident by a staff member. The CIR did not include the LTCH analysis and outcome of investigation of the incident.

The Administrator confirmed that this report did not include the above-mentioned information.

There was no impact to the resident when the home failed to include the analysis and outcome of the investigation in the CIR.

Sources: CIR, home's investigation notes and interview with staff.