

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 20, 2025 Inspection Number: 2025-1139-0002

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 18-20, 2025 The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

- Intake related to an outbreak.
- Intake related to Improper/incompetent care of a resident.
- Intake related to a resident fall resulting in injury and subsequent transfer to hospital.

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

Skin and Wound Prevention and Management Infection Prevention and Control Prevention of Abuse and Neglect Responsive Behaviours Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 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 failed to ensure a resident received weekly skin and wound assessments related to an area of altered skin integrity. A review of the resident's clinical records identified an initial skin and wound assessment being completed for their altered skin integrity, however no other skin and wound assessments were completed thereafter. Registered Nurse (RN) #107 confirmed weekly skin and wound assessments had not been completed for the resident.

Sources: The resident's clinical records and interview with RN #107. [000744]