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: April 24, 2025

Inspection Number: 2025-1139-0003

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): April 14-17 and April 22-24, 2025.

The following intake(s) were inspected:

- An intake related to the fall of a resident with injury, hospitalization, and change in condition
- An intake related to a complaint regarding a resident's care, documentation, and communication

The following intake was completed in this inspection:

- An intake related to the fall of a resident with subsequent injury

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

Resident Care and Support Services
Infection Prevention and Control
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) 3.
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:
3. Every resident has the right to have their participation in decision-making respected.

The licensee failed to ensure that a resident's right to have their participation in decision-making in relation to physiotherapy services was respected.

A resident was assessed by a Physiotherapist (PT) on a specified date and was entered into the home's physiotherapy program. The PT acknowledged that the outcome of the assessment and updates on the resident's progress with physiotherapy services were not discussed with the resident's Substitute Decision Maker (SDM).

Sources: Health records for a resident and interview with the PT.

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 that staff utilized a safe transferring technique when assisting a resident from the floor following a fall. The resident was manually lifted by staff without the use of a mechanical lift. Assistant Director of Care (ADOC) confirmed the home has a "no lift" policy and that staff are not to manually lift residents. The Director of Care (DOC) confirmed that the expected practice would be to use a mechanical lift to assist a resident on the floor.

Sources: Health records for a resident, Home's Resident Fall Prevention Program Policy, Home's Resident Lift and Transfer Program Policy, and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

1.The licensee failed to comply with the home's Falls Prevention and Management Program when the Head Injury Flow Sheet for a resident, in relation to an unwitnessed fall that occurred on specified date, was not completed at the designated intervals as per the home's policy.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Falls Prevention and Management Program were complied with.

Specifically, the home's Resident Fall Prevention Program Policy indicated that a head injury routine will be initiated for 48 hours if there is a suspected head injury or unwitnessed fall.

Registered staff acknowledged that the Head Injury Flow Sheet was initiated for the resident following an unwitnessed fall and confirmed that intervals following the initial assessment were missed. The DOC confirmed that the Head Injury Flow Sheet was not completed for all intervals.

Sources: Health records for a resident, Home's Resident Fall Prevention Program Policy, and interviews with staff.

2.The licensee failed to comply with the home's Falls Prevention and Management Program when strategies to reduce or mitigate falls, including the implementation of falls prevention related equipment were not implemented in accordance with the resident's assessed fall risk on a specific date. The licensee also failed to comply with the home's Falls Prevention and Management Program when the resident's fall risk was not monitored by re-assessment when the resident experienced a significant change in condition during a specified time period.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Falls Prevention and Management Program were complied with.

Specifically, the home's Resident Fall Prevention Program Policy indicated that registered staff will develop an individualized care plan with interventions targeted to the results of the risk assessment and the identified risk factors. The policy also outlined that assessment of a resident's fall risk is to be conducted using the Scott Fall Risk Assessment and that re-assessment with this tool is required when a resident experiences a significant change in their health status.

The resident was assessed to be a specific level of risk for falls on a certain date, however, the strategies/interventions implemented did not reflect the strategies/interventions expected for the resident's assessed risk level. The DOC acknowledged that the implementation of strategies/equipment expected for this risk level were not reflected in the resident's plan of care.

The resident experienced a significant change in their health status during a specified time period. The resident’s fall risk was not re-assessed at this time. The previously implemented precautions and falls risk remained in place when the resident sustained an unwitnessed fall on certain date, resulting in a significant injury.

Sources: Health records for a resident, Resident Fall Prevention Program Policy, interviews with staff.

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