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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Public Report

Report Issue Date: December 19, 2024
Inspection Number: 2024-1234-0001
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 Aylmer, Aylmer

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19, 21, 22 and November 25-28, 2024

The following intake(s) were inspected:

- Intake: 00130679 - Complaint related to care.
- Intake: 00131773/Critical Incident #2740-000015-24 - Fall with injury.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Pain Management
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 the resident's 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.

The licensee failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality.

Rationale and Summary

A witnessed interaction occurred in which a staff member used inappropriate language in front of a resident and within a resident home area.

A review of the home's investigation notes concluded that inappropriate communication occurred in a resident home area.

During an interview with the DOC, it was confirmed that a staff member used inappropriate language in front of the resident.

There was a risk to the resident related to the lack of courtesy and respect provided during their care.

Sources: Review of the home's investigation notes and an interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The home has failed to ensure that alleged improper/incompetent care was reported to the Director immediately.

Rationale and Summary
During an inspection of a complaint related to alleged improper care, the home's internal investigation notes were reviewed. The homes internal investigation concluded that rough care had been provided to a resident.

It was acknowledged during an interview with the DOC that the improper or incompetent care was not reported to the Director as required.

The home's failure to report to the Director immediately created a potential risk to the residents of the home.

Sources: Review of the homes internal investigation notes and an interview with the DOC.

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's falls prevention and management program was followed. Specifically, where staff were required to complete the head injury routine (HIR) in full, including documentation, for monitoring a resident post fall.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the requirements outlined in the homes HIR policy.

Rationale and Summary:
A Critical Incident (CI) was reported to the Director for an unwitnessed fall involving a resident.

The licensee failed to follow the Head Injury Routine (HIR) included in the Falls

Prevention and Management Program.

The resident required a HIR assessment. Staff initiated the HIR using the wrong date. Assessment entries were incomplete, missing pain assessments, signatures, and progress notes to indicate that staff attempted to complete the assessment or re-approached the resident when they refused.

During an interview, staff confirmed that if a resident refused an assessment, there should be supporting documentation in progress notes.

There was a risk to the resident that signs of a head injury might not be detected due to the incomplete assessments and documentation of the HIR following an unwitnessed fall.

Sources: Review of resident's clinical records, CI, and the home's HIR policy, and interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the home's pain management program was followed. Specifically, where staff were required to complete a Comprehensive Pain Assessment.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a pain management program, which includes the monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the requirements outlined on the homes Pain Management Program Policy.

Rationale and Summary
A Critical Incident (CI) was reported for an unwitnessed fall involving a resident, which resulted in injury.

The home's Pain Management Program policy required registered staff to assess residents for pain in situations such as falls or when pain persists or worsens. The policy also directed staff to complete comprehensive pain assessments for new or worsening pain not easily managed.

A review of clinical records showed that the resident reported pain and exhibited signs of discomfort following the fall. Documentation indicated that the resident showed signs and symptoms of potential ongoing pain. Despite these indications, no additional comprehensive pain assessments were completed for an extended period after the initial assessment.

The Director of Care confirmed that staff were expected to complete a pain assessment when pain persisted or when full assessment was not possible, but this was not done.

The lack of timely and comprehensive pain assessments increased the risk of delayed care and treatment for the resident.

Sources: Record review of the home's Pain Program Policy, clinical records and

interview with the DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the direction for use specified by the prescriber.

Rationale and Summary
A resident returned to the home, but registered staff were not aware of their return until some time later. This delay resulted in the resident's prescribed medication not being administered as per the prescriber's orders.

An interview with a registered staff member confirmed that the resident did not receive their prescribed medication until staff became aware that the resident was back in the home.

A review of the resident's clinical records showed that the medications were administered significantly later than prescribed.

During an interview with the DOC, it was confirmed that the resident's medication was not administered in accordance with the direction for use specified by the prescriber.

There was a risk to the resident's optimal effective outcome of care related to the delay in administration of medications.

Sources: Residents' health care records and interviews with Registered Staff and the DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee failed to ensure that a medication incident involving a resident was documented, including a record of immediate actions taken to assess and maintain the resident's health. The incident was not reported to the resident, their substitute decision-maker (SDM), the prescriber, the attending physician, or the registered nurse in the extended class attending the resident.

Rationale and Summary

A resident had medications scheduled for administration; however, records indicated the medications were administered significantly later than scheduled.

During an interview, the Director of Care confirmed that no medication incident report was completed for this occurrence, contrary to the home's policy, which requires documentation of all medication errors.

Failure to notify the resident's physician prevented timely direction regarding the late administration. The lack of documentation and communication increased the risk of diminished therapeutic outcomes. These omissions could delay recognition and response to potential adverse effects, placing the resident's health at risk.

Sources: Residents' health care records and an interview with the DOC.