

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**London District**  
130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

**Original Public Report**

<b>Report Issue Date:</b> September 12, 2023	
<b>Inspection Number:</b> 2023-1141-0003	
<b>Inspection Type:</b> Proactive Compliance Inspection	
<b>Licensee:</b> Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
<b>Long Term Care Home and City:</b> AgeCare Parkhill, Parkhill	
<b>Lead Inspector</b> Cheryl McFadden (745)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Tatiana Pyper (733564) Christie Birch (740898)	

**INSPECTION SUMMARY**

<p>The inspection occurred onsite on the following date(s): August 17, 18, 21, 22, 23, 24, 2023</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> <li>Intake: #00094569 - Proactive Compliance Inspection (PCI)</li> </ul>
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The following **Inspection Protocols** were used during this inspection:

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management
- Residents’ and Family Councils
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Quality Improvement

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Residents' Rights and Choices  
Pain Management  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Air Temperature

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

Non-compliance with: O. Reg. 246/22, s. 24 (4)

The Licensee failed to ensure that for any resident room, which was not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

#### Rationale and Summary

During a proactive compliance inspection (PCI) at the home, the Administrator/Director of Care (Adm/DOC) indicated that the home was cooled with tempered air in the hallways and portable air conditioning units in each resident room except for a specified room.

The home's policy, Heat Risk and Cold Weather Precautions, originated May 2012, last revised April 2023 noted in Procedure 1; "In addition to the requirements above, every resident bedroom that is not served by air conditioning, must have a temperature measured and documented in writing each day in the afternoon between 12 p.m. and 5 p.m."

A record review of the air temperature logs for the month of August 2023, noted that on 12 dates the air temperature was not recorded for a specified room between 12 p.m. and 5 p.m.

During an interview with a RN and the Adm/DOC, they acknowledged that the temperatures for the identified room were missing on those dates and would expect they should have been completed and documented.

There was an increase in risk to the resident related to heat related illnesses.

**Sources:** Interview with Adm/DOC and staff, Air temperature logs.  
[740898]

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## WRITTEN NOTIFICATION: Uninstalling portable or window air conditioning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 23.2 (4)

The licensee failed to ensure that there was a written record that was kept relating to the uninstallation of the portable air conditioning unit in a specified room, including the date the unit was uninstalled and the circumstances that led to the unit being uninstalled.

### Rationale and Summary

During a proactive compliance inspection (PCI) at the home, the Administrator/Director of Care (Adm/DOC) indicated that the home was cooled with tempered air in the hallways and portable air conditioning units in each resident room except for one specified room at the resident's request.

After record review and interviews, no written record was located identifying the date the air conditioner was removed from the room or the circumstances that led to the removal of the air conditioner from the room.

**Sources:** Progress notes, careplan in Point Click Care (PCC), interview with Adm/DOC, staff and family member, Air temperature logs  
[740898]

## COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**  
Specifically, the licensee shall:

1. Ensure tracking of skin and wound concerns and documentation of data is collected as per the home's Skin and Wound Program. Conduct weekly audits of the Skin and Wound Tracking Workbook to ensure that data in the workbook is collected as required. Ensure that the date of the audit, the person

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responsible, and the results of the audit are documented.

2. Conduct monthly audits of the Skin and Wound Tracking Workbook to ensure that data in the workbook is analyzed at a minimum quarterly by the Skin Care Committee and action plans are developed where there is an increase in trends of skin integrity alteration.

3. Ensure that the Skin and Wound Lead participates in the quarterly and annual review of trends and action plans related to the skin care program. Ensure the meeting minutes are documented and kept on file. Ensure the date of meeting, the participants and the outcome of the meeting are documented.

**Grounds**

The licensee has failed to comply with the Skin and Wound Care Program in the home for the Skin and Wound Tracking Workbook.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee was required to ensure the Skin and Wound Care Policy, number: LTC-CA-BC-ON-200-08-01, revised June 2023 was complied with as a part of the Skin and Wound Care Program.

The home's Skin and Wound Care Policy, number: LTC-CA-BC-ON-200-08-01, revised June 2023, stated that the skin and wound care coordinator was responsible to ensure the home's skin and wound workbook was kept current with required skin and wound data. Additionally, the home's skin and wound policy stated that the skin and wound data collected by the home into the workbook was to be analyzed at a minimum quarterly by the Skin Care Committee, and action plans developed where there was an increase in trends in skin integrity alterations.

Review of the Skin and Wound Tracking Workbook for January, February and March 2023 indicated that the required data was not tracked as required several times during January, February, and March 2023, and there was no other documented or completed analysis of the skin and wound concerns identified in the home.

The home Skin and Wound Care Coordinator stated that they did not have dedicated time to complete their skin and wound care lead responsibilities and would complete them when possible.

Director of Care (DOC) acknowledged that the Skin and Wound Tracking Workbook for January, February and March 2023 was not completed as required by the home's Skin and Wound Care policy. There was a risk that wound care issues and practices were not regularly reviewed and revised as a result of the Skin and Wound Tracking workbook not being completed.

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**Sources:** review of the home's Skin and Wound Tracking Workbook; review of Chartwell Parkhill Skin and Wound Care Policy, number: LTC-CA-BC-ON-200-08-01, revised June 2023; interview with Skin and Wound Lead and Director of Care.

[733564]

**This order must be complied with by October 20, 2023**

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## **REVIEW/APPEAL INFORMATION**

### **TAKE NOTICE**

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

### **Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).