

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

London District

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

Original Public Report

Report Issue Date: September 16, 2024

Inspection Number: 2024-1141-0003

Inspection Type: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 Parkhill, Parkhill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26, 27, 28, 2024

The following intake(s) were inspected:

• Intake: #00122959 - Critical Incident (CI) report # 2632-000005-24 related to the abuse of a resident.

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

Infection Prevention and Control Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training



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 **London District**

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

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

Non-compliance with: FLTCA, 2021, s. 82 (2) 4.

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

4. The duty under section 28 to make mandatory reports.

The licensee has failed to ensure that a staff member received training on the duty under section 28 to make mandatory reports..

Rationale and Summary:

During an interview, a staff member revealed that they had not completed the required education on mandatory reporting.

The inspector asked to review the staff member's educational records and was informed by email from the home's Assistant Director of Care (ADOC)that the staff member's file lacked any education on mandatory reporting.

The ADOC confirmed in an interview and by email that the staff member had not completed the required education..

Failure of the home to ensure that staff completed mandatory reporting training increased the risk of staff not following the home's reporting practices.

Sources: Interviews with staff and the ADOC

[705241]