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: January 27, 2025
Inspection Number: 2025-1141-0001
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): January 21, 23, 24, 27, 2025

The following intake(s) were inspected:

- Intake: #00134806 - 2632-000016-24 - Related to the prevention of abuse and neglect.
- Intake: #00136985 - 2632-000002-25 - Related to disease outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to be treated with respect

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 a resident's right to be treated with courtesy and respect, in a manner that fully recognizes their inherent dignity, worth, and individuality, was upheld during personal care provided by a Personal Support Worker (PSW).

An incident of alleged abuse occurred involving a personal support worker (PSW), who placed an object on a resident as a joke while the resident was waiting for assessment by the registered staff. The Assistant Director of Care (ADOC) stated that the PSW acknowledged their actions, which did not align with the resident's rights to be treated with dignity and respect.

Sources: Home's investigation Notes, interviews with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with for an incident of alleged sexual abuse of a resident a by Personal Support Worker (PSW).

Specifically, a PSW did not comply with the licensee's "Abuse allegation and follow-up" policy (LTC-ON-100-05-02, revised July 2024). According to the policy, staff must immediately report any observed or reported abuse to the Executive Director/DOC or Supervisor/Manager on Duty. The PSW admitted they did not immediately report the incident.

Sources: Critical Incident System (CIS) report #2632-000016-24, the home's Abuse allegation and follow-up Policy, and interviews with staff.