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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 20, 2024	
Inspection Number: 2024-1298-0003	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Pine Grove, Woodbridge	
Lead Inspector Matthew Chiu (565)	**Inspector Digital Signature**
Additional Inspector(s) Jack Shi (760)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4-7, 10, and 13, 2024.

The following Critical Incident System (CIS) intake(s) were inspected:
- #00111814; #00111843 related to improper care or treatment of residents;
- #00111860 related to resident injury of unknown cause.

The following Complaint intake(s) were inspected:
- #00114035 related to resident injury of unknown cause.

The following Follow-up intake(s) were inspected:
- #00113792 related to follow-up of compliance order (CO) #003 from inspection #2024-1298-0002;

- #00113793 related to follow-up of CO #002 from inspection #2024-1298-0002;
- #00113794 related to follow-up of CO #001 from inspection #2024-1298-0002.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2024-1298-0002 related to O. Reg. 246/22, s. 40 inspected by Matthew Chiu (565)

Order #002 from Inspection #2024-1298-0002 related to FLTCA, 2021, s. 6 (7) inspected by Jack Shi (760)

Order #001 from Inspection #2024-1298-0002 related to FLTCA, 2021, s. 24 (1) inspected by Jack Shi (760)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to their treatment program.

Rationale and Summary:
The resident had a SDM for their care and had been receiving treatment through a specified program for their health condition. On a specified date, it was documented that the resident was discharged from the program. Record reviews and staff interviews confirmed that the resident's SDM was not informed about the discharge. The Director of Care (DOC) acknowledged that the SDM was not given an opportunity to participate in the development and implementation of the resident's discharge planning.

Failure to provide the SDM with the opportunity to participate in the resident's discharge planning posed a risk of inadequate continuity of care, potentially jeopardizing their ongoing needs and preferences.

Sources: Resident's progress notes and assessment records; interviews with the Registered Practical Nurse (RPN), Physiotherapist (PT), and the DOC. [565]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure a Personal Support Worker (PSW) provided care to a resident in accordance to their plan of care.

Rationale and Summary:
A complaint and CIS report were submitted to the Ministry of Long-Term Care regarding a resident's injury. The home's investigation revealed, and the PSW confirmed, that they had provided care to the resident without following the specified assistance that the resident required. The DOC acknowledged that the specified assistance set out in the resident's care plan was required for their care, and it was not provided by the PSW.

Failure to ensure that the resident's plan of care was followed increased their risk of injury.

Sources: Home's investigation notes, resident's care plan; interviews with the PSW and DOC. [760]

WRITTEN NOTIFICATION: Plan of Care

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that a PSW was kept aware of the contents in a resident's plan of care and had convenient and immediate access to it.

Rationale and Summary:
A complaint and CIS report were submitted to the Ministry of Long-Term Care regarding a resident's injury. During the home's investigation, the PSW had stated that they had difficulty accessing the resident's care plan on a separate application used by staff members and were unable to gain full access to the home's systems for the resident's plan. The DOC confirmed that the PSW did not review the resident's care plan on PointofCare (POC) or PointClickCare (PCC) and were not informed of the contents of the resident's plan of care.

Failure to be aware of the contents in the resident's plan of care resulted in the staff member giving care to the resident in a manner that did not align with the plan of care and increased the resident's risk of injury.

Sources: Home's investigation notes related to the incident; interviews with the PSW and DOC. [760]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 licensee has failed to ensure that when a registered staff member had reasonable grounds to suspect improper care of a resident, which resulted in a risk of harm to the resident, they immediately reported the suspicion to the Director.

Rationale and Summary:
Record reviews and staff interviews revealed that during a shift, a PSW provided care to a resident. During this process, a RPN was called to attend to an injury sustained by the resident and became aware that the PSW had performed the care alone. Despite recognizing that this method of care posed a risk of injury to the resident and was improper, the RPN did not report the incident to their on-call manager or to the Director.

The DOC stated that the registered staff should have reported the incident to their on-call manager, themselves, or directly to the Director. The DOC confirmed that the incident was not reported to the Director immediately.

Failure to immediately report the improper care of the resident, that resulted in a risk of harm, to the Director did not place the resident at risk.

Sources: Resident's progress notes, care plan; interviews with the PSW, RPN, and

DOC. [565]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 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 has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary:
A resident had a physical impairment requiring specific assistance for safe transferring. Record reviews and staff interviews revealed that during a shift, the resident requested assistance for care. When the PSW attended to the resident, they transferred them using a different technique. Further record reviews and staff interviews indicated that the resident did not have the necessary capability for the transferring technique used by the PSW, making it unsafe to transfer them in this manner. The DOC confirmed that the technique used by the PSW posed a safety risk during the resident's transfer.

Failure to utilize safe transferring techniques for the resident has placed the resident at risk of injuries.

Sources: Resident's progress notes, care plan, POC and home's investigation records; interviews with the PSW, RPN, and DOC. [565]