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
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Public Report

Report Issue Date: May 5, 2025
Inspection Number: 2025-1298-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22, 24, 25, 29, 30, 2025 and May 1, 2, 5, 2025
The inspection occurred offsite on the following date(s): April 28, 2025

The following intake was inspected in this complaint inspection:
• Intake: #00142494 - related to a bed refusal.

The following intake was inspected in this Critical Incident (CI) inspection:
• Intake: #00143800 - Critical Incident (CI) #2808-000006-25 related to allegation of staff to resident abuse.

The following intake was inspected:
• Intake: #00140344 - Follow-up on a previously issued Compliance Order (CO) related to O. Reg. 246/22 - s. 53 (1) 1.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1298-0002 related to O. Reg. 246/22, s. 53 (1) 1.

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

Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in a resident's care collaborated in the assessment, development, and implementation of the resident's plan of care.

A Personal Support Worker (PSW) reported that a resident exhibited responsive behaviours during personal care. In review of the resident's clinical records there was no documentation of the resident's responsive behaviours.

The Director of Care (DOC) acknowledged the PSW failed to report the resident's responsive behaviours to a nurse to facilitate the assessment of the resident.

Sources: Resident's clinical records; and interviews with the PSW and the DOC.