

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

Public Report

Report Issue Date: August 25, 2025

Inspection Number: 2025-1298-0004

Inspection Type:

Complaint
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 Pine Grove, Woodbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 18-22, 25, 2025

The following complaint intake was inspected:

- Intake: #00154585 - related to an injury of unknown cause of a resident

The following Critical Incident (CI) intakes were inspected:

- Intake: #00151581 [CI: 2808-000011-25] - related to an improper repositioning of a resident resulting in injury
- Intake: #00152641 [CI: 2808-000012-25] - related to an injury of unknown cause of a resident

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

Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for a resident included the use of a falls prevention intervention. An observation revealed the use of the falls prevention intervention. Interviews with two Registered Nurses (RN) confirmed that the intervention was implemented as a fall prevention strategy. However, this intervention had not been documented in the resident's written plan of care. The care plan was subsequently updated on August 21, 2025, after it was brought to the home's attention.

Sources: Review of a resident's clinical records, a Critical Incident Report (CIR), and interviews with staff.

Date Remedy Implemented: August 21, 2025

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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 and positioning techniques when assisting a resident. A Personal Support Worker (PSW) assisted the resident with repositioning, however they fell and experienced a negative health outcome. The PSW acknowledged that the required level of assistance as per the resident's plan of care was not provided during the activity.

Sources: Review of a resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Required Programs

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

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to comply with the home's pain management program when a resident's pain was not immediately reported to the registered staff.

In accordance with O. Reg. 246/22, s. 11(1)(b), the licensee was required to ensure that written policies developed for the pain management program were complied with.

Specifically, the home's pain management policy indicated that care staff were required to report signs of pain to the registered staff immediately. A resident complained of pain prior to being transferred by two PSWs. The registered staff was not informed of the resident's pain until several hours later, at which time the resident experienced further health decline.

Sources: A resident's clinical records; Home's policy titled "Pain Management Program", LTC-ON-200-05-06, revised July 2024; Home's investigation notes; and interviews with staff.