Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: November 15, 2023	
Inspection Number: 2023-1383-0006	
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 Trilogy, Scarborough	
Lead Inspector Carole Ma (741725)	**Inspector Digital Signature**
Additional Inspector(s) Kirthiga Ravindran (000760)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30 - 31, November 1 - 2, 6 - 8, 2023
The inspection occurred offsite on the following date(s): November 3, 2023

The following Critical Incident intakes were inspected:
- Intake: #00096410 – Related to a fall resulting in a change of resident health status
- Intake: #00098308 – Related to glucagon use and subsequent transfer of resident to the hospital
- Intake: #00099917 – Related to COVID-19 outbreak
- Intake: #00100189 – Related to RSV outbreak

The following Complaint intake was inspected:
- Intake: #00098696 – Related to resident care concerns

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

Falls Prevention and Management
Infection Prevention and Control

Medication Management
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.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary
A resident fell resulting in injuries that caused a change to their health status.

During a specific period of time, that included when this fall incident occurred, the long-term care home (LTCH) relied upon paper documentation as their electronic database was inaccessible. After the fall, two staff members made handwritten notes to update the resident's paper clinical records with fall prevention interventions.

A Personal Support Worker (PSW) indicated that staff accessed this type of resident clinical record digitally, on tablets. They indicated they were, however, aware of an updated fall prevention intervention, and the Inspector observed this in practice.

The Clinical Coordinator (CC) acknowledged the resident's electronic clinical record was not updated. After the interview, this was completed.

Sources: Resident's clinical records, interviews with PSW and CC. [741725]

Date Remedy Implemented: November 8, 2023

WRITTEN NOTIFICATION: PLAN OF CARE WHEN REASSESSMENT, REVISION REQUIRED

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee had failed to ensure that a resident was reassessed and the plan of care reviewed when care set out in the plan had not been effective.

Rationale and Summary
On a number of specific dates, a resident had blood sugar (BS) readings indicating incidents of hypoglycemia, according to the long-term care home’s (LTCH) policy. The Registered Practical Nurse (RPN) confirmed the readings were completed by them. The RPN stated they had provided the resident with interventions and acknowledged they did not take any further actions to have the resident reassessed.

The Assistant Director of Care (ADOC) and the Director of Care (DOC), indicated that the home's policy for this specific issue was not followed, and appropriate follow-up actions to have the resident assessed were not completed.

Failure to have the resident reassessed and the plan of care reviewed when management of their chronic health condition was not effective, put the resident at risk for an acute incident.

Sources: Resident's clinical records, LTCH's Hypoglycemia and Glucagon policy, Interview with RPN, ADOC and DOC. [000760]

WRITTEN NOTIFICATION: PLAN OF CARE INVOLVEMENT OF RESIDENT, ETC.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure 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.

Rationale and Summary
The Director received a complaint from an SDM, alleging the resident had not had a specific personal care need met, and that the LTCH had not informed them. In a follow up telephone call, the SDM also

indicated they were not informed when the care provider wrote a treatment order.

The resident was scheduled to receive specialized services for a personal care need at regular intervals. Their clinical records indicated they consistently refused these services consecutively over a period of time. On a specific date, the care provider was able to provide the services and wrote a treatment order.

The resident's clinical records provided no indication that the SDM was contacted after each refused appointment during this time frame, or when the treatment order was made.

A Facility Charge Nurse (FCN) indicated that the SDM should have been made aware when the appointments were refused. They also confirmed the SDM was not informed of the treatment order.

In failing to ensure the SDM was informed of the resident's continuous service refusals and of the treatment order, the SDM was excluded from providing support to the resident's plan of care.

Sources: Resident #001's clinical records, interviews with FCN #106, DOC. [741725]

WRITTEN NOTIFICATION: PLAN OF CARE DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the plan of care for two residents was followed as specified in the plan.

Rationale and Summary
1) A resident was scheduled to receive specialized services for a personal care need at regular intervals. Their clinical records indicated they consistently refused these services consecutively over a period of time.

The resident's care plan confirmed these specialized services and noted that the resident would frequently refuse or would stop being cooperative midway through the procedure. The care plan also noted as of a specific date, that registered staff would administer as needed (PRN) medications during these appointments to allow the resident to be more cooperative during the procedure.

The resident's records indicated this intervention was in place. During this period of consecutive service refusals, the resident never received this intervention during the specialized services.

The DOC confirmed the resident's records showed that there were interventions in place but not provided, in relation to these specialized services.

In failing to ensure the resident’s plan of care was followed, there were missed opportunities in supporting the resident to potentially become more cooperative in having their personal care needs met.

Sources: Resident's clinical records, interview with DOC. [741725]

2) A resident was given an intervention during a hypoglycemic event by an RPN. The resident's care plan stated this intervention should not be given due to an identified reason.

The RPN acknowledged they administered the intervention to the resident and that this was not in accordance with the resident's care plan. The ADOC acknowledged that the intervention should not have been given to the resident and that the care plan was not followed.

Failure to comply with care set out in the resident's care plan put the resident at increased risk of poor health outcomes.

Sources: Resident's care plan and progress notes, interviews with RPN and ADOC. [000760]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

Rationale and Summary
On a specific date, a resident home area (RHA) was on a COVID-19 outbreak. A Housekeeper (HSK) was observed wearing a surgical mask while walking in the hallway past resident rooms.

They indicated they should have been wearing an additional face shield in the hallway. To their understanding, they needed to wear an N95 mask and a face shield only if they were entering a room placed on droplet contact precautions.

The IPAC lead confirmed that the HSK was not wearing appropriate personal protective equipment (PPE) and that on an outbreak unit staff were required to wear an N95 mask and face shield.

The failure of the staff member in understanding and following the IPAC program during a COVID-19 outbreak placed residents at risk for infection transmission and a prolonged outbreak.

Sources: Observations, interviews with HSK and IPAC lead. [741725]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)

The licensee failed to ensure that when they were required to make a report immediately and it was after normal business hours, the report was made using the Ministry's method for after hours emergency contact.

Rationale and Summary
On two specific dates, Critical Incident System (CIS) reports were submitted after normal business hours for disease outbreaks in the LTCH. The Service Ontario After-Hours Line was not contacted in accordance with the Director's memo, "Reporting Requirements for LTC Homes". Specifically, the Director's memo stated that if outside of business hours, to call the Service Ontario After-Hours Line, and submit a CIS report the next business day.

During an interview with the DOC and ADOC they acknowledged that the Service Ontario After-Hours Line was not contacted and should have been contacted.

Sources: CIS reports, Interviews with ADOC and DOC, Director's memo: Reporting Requirements for LTC Homes (last revised June 2023, sent out August 18, 2023). [000760]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 6.

The licensee failed to ensure that the Director was informed within one business day when a resident was administered glucagon and taken to the hospital.

Rationale and Summary
A resident was administered glucagon and taken to hospital. The licensee submitted a CIS report two days after the incident.

The Director's memo and the LTCH's policy indicated that when glucagon was administered and the resident is taken to hospital, the Director must be notified no later than one business day. The ADOC acknowledged that the Director was not notified within one business day of this incident.

Sources: CIS report, interview with ADOC. [000760]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the system to accurately administer glucagon to a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration of glucagon.

Specifically, staff did not comply with the policy "Hypoglycemia and Glucagon", which was included in the licensee's Medication Management Program. The Hypoglycemia and Glucagon policy indicated appropriate carbohydrate options to administer to a resident experiencing hypoglycemia, and the correct intervals for BS testing.

Rationale and Summary
On a specific date, a resident had a hypoglycemic incident. In response, the RPN administered an intervention. The resident required further interventions to improve their condition and these interventions were provided accordingly, along with BS re-testing.

The RPN, however, failed to administer an appropriate form of the intervention when the resident was

in a hypoglycemic state and also failed to perform the required BS testing at the correct time intervals.

The RPN acknowledged that they did not follow the Hypoglycemia and Glucagon policy during the hypoglycemic event for the resident. The ADOC and DOC acknowledged the Hypoglycemia and Glucagon policy was not followed during this incident.

Failing to comply with the Hypoglycemia and Glucagon policy put the resident at risk for an acute incident.

Sources: Resident's progress notes, LTCH's Hypoglycemia and Glucagon policy (last revised June 2023), interviews with RPN, RN, ADOC and DOC. [000760]