

**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:** May 31, 2024

**Inspection Number:** 2024-1383-0002

**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

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 27, 28, 29, 2024.

The following intake(s) were inspected:

- Intake: #00112836 - Critical Incident Systems (CIS) #2899-000004-24 - Allegation of neglect of a resident
- Intake: #00115058 and 00115161 - Complaints related to allegations of neglect and improper care of a resident

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

Skin and Wound Prevention and Management  
Food, Nutrition and Hydration  
Infection Prevention and Control  
Prevention of Abuse and Neglect

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)**

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to comply with the policies and procedures developed to address nutritional care.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is the development and implementation of policies and procedures relating to nutritional care and must be complied with.

Specifically, staff did not comply with the policy "Food and Fluid Intake", dated June 2023, which was included in the licensee's Nutrition and Hydration Program.

### Rationale and Summary

A complaint was forwarded to the Ministry of Long-Term Care (MLTC) related to an allegation of staff's failure to provide adequate nutritional care to a resident.

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A review of Point of Care (POC) documentation indicated that the resident experienced a change in their nutritional intake during a period of time, which was also supported by the documentation from the resident's progress notes.

The home's Food and Fluid Intake policy indicates that a referral to the Registered Dietitian (RD) should be made when a resident has a reduced food intake for a period of three days or more. A referral to the RD was completed beyond a period of three days, when the resident was experiencing a change in their food intake.

The Facility Charge Nurse (FCN) stated that an earlier referral to the RD may have been beneficial to the resident's wellbeing, given a change in their food intake. The RD stated that based on the documentation from the staff and the home's policy, a referral to the RD would have been required earlier than when the actual referral was sent to them.

Failure to involve the RD earlier in assessing the resident may have led to missed opportunities for timely nutritional interventions.

**Sources:** Home's policy, titled "Food and Fluid Intake", dated June 2023; Review of POC, assessments and progress notes documentation; Interview with the FCN, the RD and other staff. [760]