Ontario

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 17, 2024
Inspection Number: 2024-1423-0002
Inspection Type: 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 Royal Oak, Kingsville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 17, 18, 20, 21, 24 - 28, 2024
The inspection occurred offsite on the following date(s): June 19, 24-27, 2024

The following intake(s) were inspected:

- Intake: #00114945 - Critical Incident (CI) #2939-000013-24 relating to resident to resident responsive behaviours.
- Intake: #00116638 - CI #2939-000017-24 - relating to resident to resident responsive behaviours.
- Intake: #00116974 - CI #2939-000018-24 - relating to an allegation of abuse.
- Intake: #00117876 - CI #2939-000020-24 - relating to resident to resident responsive behaviours.
- Intake: #00117942 - CI #2939-000021-24 - relating to an allegation of neglect.
- Intake: #00117997 - CI #2939-000022-24 -relating to resident to resident responsive behaviours.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

Introduction:
The licensee failed to ensure that a resident received care in a timely manner.

For the purposes of the Act, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary:
A resident frequently required assistance from staff for care. It was documented that the resident received care and did not receive care again for several hours.

A staff member documented the next day, that the resident's condition, for which they had a treatment, was worsening.

The Director of Care (DOC) acknowledged that the resident was not provided care in a timely manner, and the expectation would have been that they were checked at the start of the afternoon shift and care for before and/or after dinner. The DOC also stated that through interviews with staff they determined that the resident's condition had worsened from the previous week.

Not providing the resident with the required care increased the risk for worsening of their condition.

Sources: Critical incident (CI), resident's clinical records, as well as an interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Introduction
The licensee failed to ensure that an incident of abuse and neglect was reported immediately to the Director.

Rationale and Summary
An incident relating to abuse of a resident occurred. The Director was informed of this incident four days later. During an interview with the Assistant Director of Care (ADOC), it was acknowledged that the Director was not immediately informed of this incident.

Sources
CI report, Interview with the ADOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Introduction:
The licensee failed to ensure that a resident, who was exhibiting impaired skin integrity, received a skin assessment by an authorized person using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:
It was documented that a resident had altered skin integrity. An assessment of this area was not completed using a clinically appropriate assessment instrument until three weeks later.

The home's policy titled, "Skin and Wound Care Program", included in part that, all residents who exhibited altered skin integrity, including skin breakdown, were to have received a skin assessment by a registered staff member.

The ADOC acknowledged that an initial assessment should have been completed for the area of impaired skin integrity and was not.

Not completing an initial assessment of the area of impaired skin integrity put the resident at risk for worsening skin impairment.

Sources: Resident's clinical records, as well as the home's skin and wound policy, and an interview with ADOC.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

Introduction:
The licensee failed to ensure that a resident's area of impaired skin integrity was reassessed at least weekly by an authorized person.

Rationale and Summary:
It was documented that a resident had an area of altered skin integrity. The reassessment of this area was not completed until two weeks later.

The home's policy titled, "Skin and Wound Care Program", included in part that, all residents exhibiting altered skin integrity, including skin breakdown, were to have had weekly reassessments until healed.

The DOC acknowledged that a weekly skin assessment should have been completed for the area of altered skin integrity and was not.

Not completing weekly skin assessments of the area of altered skin integrity put the resident at risk for worsening skin impairment.

Sources: Resident's clinical records, as well as the home's skin and wound policy, and interview with the DOC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

Introduction
The licensee failed to ensure that a resident had strategies for responsive behaviour management fully implemented.

Rational and Summary
The care plan for a resident stated they should have had a responsive behaviour intervention in place. A progress note documented that the resident did not have the intervention in place and an incident had occurred with another resident.

During an interview with the DOC they indicated, the expectation would have been that the intervention would have been in place and was not.

By not ensuring the intervention was in place the licensee did not fully implement the developed strategies for responding to the resident's behaviours and increased their risk of demonstrating responsive behaviours.

Sources: Clinical records and staff interviews.

COMPLIANCE ORDER CO #001 Accommodation services

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (a) [FLTCA, 2021, s. 155 (1) (b)]:
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment and ensure they are kept clean and sanitary.
A. Complete an audit of all the Resident Home Areas (RHA) and serveries to identify floors, walls, windowsills, and all other areas of uncleanliness.
B. Complete a checklist of the cleaning to be done which includes where, how, who would be responsible for completing the work, when the work will be started, when it will be completed and how it will be maintained.
C. Ensure that the leadership team participates in creating the plan, including the Administrator, Director of Care (DOC), Environmental Service Manager (ESM) and the Food and Nutrition Manager.

Grounds
The licensee failed to ensure the home, furnishings and equipment were kept clean and sanitary.

Rationale and Summary
During a tour of the home, every RHA was noted to have a varying degree of unkept cleanliness.

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The main entrance carpeting leading to the three hallways leading to the RHA's were noted to have multiple dark stains. The yellow vinyl flooring throughout the Mulberry, Blue Spruce, Magnolia and Copper Beech units were noted to have had a dark gray hue, with multiple dark spill spots, track markings and scuffing.

Generalized throughout all of the RHA's there was dirt and grime build up noted on the residents' floors by the doorframes and what appeared to be a white spackling of paint chips from the flaking door frames stuck onto the flooring. The Administrator confirmed the white spackling was from the flaking paint from the door frames.

In the Mulberry and Blue Spruce dining rooms, there were dead bug carcass debris in the windowsills. The Mulberry unit dining room, table extenders were noted to have had a build up of food debris with visible gnats flying in the areas.

Generalized dust debris noted in the windowsills in the hallway leading to the Magnolia and Copper Beech units.

The three serveries were noted to have had a general build up and food debris under cabinets and in the dish areas. A black speckling was noted along the wall and caulking in the dish areas. The main kitchen was noted to have had general build up and food debris under cabinets and in the dish areas. A general build up of rust was noted on the main kitchen ceiling.

The main staff entrance was noted to have had a build of of debris, dead bug carcasses, cobwebs and spider nests. The service entrance was noted to have had many dead May Fly carcasses throughout the entire back entrance.

The ESM indicated that the housekeeping staff were responsible for RHA's and

service hallways. Dietary was responsible for serveries and kitchen.

The ESM and Food and Nutrition Manager (FNM) both indicated deep cleaning and audits had not been completed routinely and that the home was not kept clean and sanitary.

Not ensuring the home, furnishings and equipment were kept clean and sanitary could have a moderate risk of impact to residents relating to residents' wellbeing and potential infection control issues.

Sources: Observation, deep cleaning audits and interviews.

This order must be complied with by October 9, 2024

COMPLIANCE ORDER CO #002 Accommodation services

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (c) [FLTCA, 2021, s. 155 (1) (b)]:
Specifically, the licensee shall prepare, submit and implement a plan to maintain the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair.
A. Complete an audit of all the RHAs including but not limited to; resident

rooms/bathrooms, shower/tub rooms, dining rooms, activity rooms and service areas to identify leaking pipes, floors, walls, doors, doorways, handrails, tub and showers, furnishing, countertops and other areas of disrepair.
B. Complete a checklist of the work to be completed, which includes; where, how, who would be responsible for completing the work, when the work will begin, when it will be completed and how it will be maintained.
C. Ensure that the leadership team participates in creating the plan, including the Administrator, DOC, and the ESM.
D. Review and revise as necessary, the preventative maintenance program to include regular audits of the maintenance of the home, furnishings and equipment to ensure they are kept in a safe condition and in a good state of repair. Keep a written record of this review, who participated, the date it occurred, and any changes made.

Grounds
The licensee failed to ensure the home, furnishings and equipment were maintained in a safe condition and a good state of repair.

Rationale and Summary
During a tour of the home every RHA was noted to have been in a varied state of disrepair. Various areas in the unit hallways had unpainted drywall patches, small holes in the drywall, large gouges in the drywall above the baseboards, missing varnish from the wooden handrails, chips in the wooden veneer around the nursing desk, paint chipped metal doorways, chipped wooden doors, stained and or missing ceiling tiles.

On the Mulberry unit there was a missing handrail, a loose handrail, a large hole covered with a plastic black garbage bag in the shower, rendering the shower

unusable. Staff had indicated the shower had been out of service for several weeks.

On the Blue Spruce unit a resident room had a large hole which appeared to have been previously repaired and broken, prior to painting, with exposed insulation. The resident who resided in the room indicated that it had been repaired and broken again before it could be painted and that the damage had been present for a while.

In the main hallway heading towards the Magnolia and Copper Beech units there was a large unfinished patch under the window of the activity/private dining room. On the Magnolia unit the emergency exit door was noted to have had corrosion and rust at the base of the doorframe. The maintenance room at the end of the second and third hallway had an active leak, towels were laid in the area where the paint had rippled, and the baseboard was peeling away. The tub was noted to have had a chip in the acrylic coating. In the shared dining room between Magnolia and Copper Beech units there were many stained and missing ceiling tiles, some of which were removed for an active leak.

On the Copper Beech unit a resident room had multiple large holes in the drywall exposing the rock and insulation, the furniture provided nightstand and wardrobe had the wooden vinyl sticker peeling away from the pressboard structure and the horizontal privacy blinds were damaged. Damage was noted to the vinyl flooring on the unit.
On the Oak unit there were missing or peeling transition flooring between the hallway and the resident rooms. The section where the second hall met the third there were large gouges in the drywall exposing the rock and insulation.

In the service hallway there were various sized scuffs and gouges in the drywall, the main staff entrance was noted to have a large amount of rust and corrosion at the base of the doorframe and the surrounding paint was noted to be rippled. The cart

wash station was noted to have missing and damaged tiles. The back service entrance doorframe was noted to be heavily rusted and corroded to the point the outside light was visible through a hole in the doorframe.

A walk through the home was completed with the Administrator and the Environmental Consultant on separate occasions and both acknowledged the current state of the home and confirmed that home and furnishings were not maintained in a good state of repair.

The ESM had indicated audits had not been completed using a written record and that the home and furnishings were not maintained in a good state of repair.

Not maintaining the home, furnishing and equipment in a good state of repair could have a moderate impact to residents' safety with risk of injury from unmaintained handrails and flooring.

Sources: Observation and resident and staff interviews.

This order must be complied with by October 9, 2024

COMPLIANCE ORDER CO #003 Orientation

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.

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2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically the licensee must;

A. Review and revise as necessary, its process for ensuring all staff receive training of the mandatory training requirements before performing their responsibilities. Keep a written record of this review, who participated, the date it occurred, and any changes made.

B. Ensure that all new staff hired pursuant to a contract, receive training on the home's mandatory training requirements, before they perform their responsibilities.

C. Complete an audit of training for all current staff hired pursuant to a contract, to determine if any staff working have not received training on the home's mandatory training requirements. Keep a record of the audit, date completed, who completed it, and results. Ensure that for any staff identified in the audit as not having completed the training, the training is provided and keep a record of the training.

Grounds
The licensee failed to ensure that no external staffing agency staff preformed their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents. Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 6 of subsection 82 (2) of the Act is amended by striking out "restraining" and substituting "restraining and confining". (See: 2021, c. 39, Sched. 1, s. 203 (16))
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The Fixing Long Term Care Act, 2021, s. 2 states: "staff", in relation to a long-term care home, means persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")

Rationale and Summary
On review of employee files for external staffing agency staff it was noted that the

agency provided the agents with prevention of abuse and neglect education. During an interview with the DOC, they confirmed that the external staffing agency trained the staff prior to working in the home, however, the education was not specific to the Long-Term Care Home's policies and procedures and did not include all of the mandatory policies and procedure training.

Not ensuring the Long-Term Care Home's (LTCH) required education was provided to the agency staff posed a moderate risk to the residents relating potential to staff preparedness in the event on an incident.

Sources: Employee files and staff interview.

This order must be complied with by August 27, 2024

COMPLIANCE ORDER CO #004 Doors in a home

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 12 (1) 1. i. [FLTCA, 2021, s. 155 (1) (b)]:
Specifically, the licensee shall prepare, submit and implement a plan to ensure that

all service entry doors are kept closed and locked when not in use.
A. Complete an audit of the door for functionality determine why the back service entrance door is not closing and locking.
B. Develop a process to ensure the door is closed and locked, include in the process a notification system for when the door does not close to alert staff to close the door.
C. Ensure that the leadership team participates in creating the plan, including the Administrator, DOC and ESM.
D. Educate all staff who are identified as responsible for ensuring the door is closed. Maintain a written record of the education provided, how it was provided and when.

Grounds
The licensee failed to ensure that the receiving door was kept closed and locked.

Rationale and Summary
During an observation with the FNM, the back receiving door was observed to be propped open. The FNM indicated the doors should not be propped and should be closed and locked when not in use.

During a separate observation the back receiving door was observed to have been cracked open and unlocked. The Administrator confirmed the door was open and should not have been. The Administrator indicated the door should have been kept closed and locked when not in use.

Not ensuring the door leading to the outside of the home was secured at all times posed a moderate potential risk for unsupervised access to the home as the door is not regularly monitored.

Sources: Observations and staff interviews.

This order must be complied with by August 27, 2024

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.