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

London District
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Original Public Report

Report Issue Date: October 9, 2024

Inspection Number: 2024-1423-0003

Inspection Type:
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 Royal Oak, Kingsville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23, 24, 25, 2024

The following intake(s) were inspected:

- Intake: #00121595 - Follow-up #1, Compliance CO (CO) #003 - FLTCA, 2021 - s. 82 (2) relating to orientation training for agency staff. Compliance Due Date (CDD) Aug 27, 2024.
- Intake: #00121597 - Follow-up #1, CO #004 - O. Reg. 246/22 - s. 12 (1) 1. i. relating to safe and secure home. CDD Aug 27, 2024.
- Intake: #00125247 - Critical Incident (CI) #2939-000032-24 - relating to resident to resident responsive behaviours.
- Intake: #00126283 - CI #2939-000033-24 - relating to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2024-1423-0002 related to FLTCA, 2021, s. 82 (2) inspected by Cassandra Taylor (725)
Order #004 from Inspection #2024-1423-0002 related to O. Reg. 246/22, s. 12 (1) 1. i. inspected by Cassandra Taylor (725)

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

Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure the care set out in the plan of care for a resident was provided as specified in the plan.

Rationale and Summary
Record review for a resident had indicated that they did not receive the care set out in the plan of care.

During an interview with the Director of Care (DOC), they had indicated that the expectation would have been that staff utilized the interventions in place and had not.

Not providing the care as specified in the plan could have had a potential negative impact to the residents overall well being and a moderate health risk as the resident had not received specific care.

Sources: Resident's clinical records, observations and staff interview.

WRITTEN NOTIFICATION: Resident records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's records were kept up to date at all times.

Rationale and Summary
An assessment was completed for a resident. On review of the assessment there

was missing documentation.

A registered staff member and the DOC both confirmed during an interview that the assessment is required to be completed in full. The DOC indicated the missing documentation should have been recorded on the assessment.

Not ensuring the assessment documentation was up to date at all times could have had a potential negative impact on the resident relating to overall review of the assessment and a low risk for a potential delay in treatment if the overall reviewed assessment had indicated a change.

Sources: Resident's clinical records and staff interviews.