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

# Original Public Report

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| **Report Issue Date: October 21, 2024** |
| **Inspection Number:** 2024-1423-0004 |
| **Inspection Type:**<br>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): October 15, 16, 17, 2024

The following intake(s) were inspected:

- CI# 2939-000035-24 - Resident to resident abuse.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Policies and Records

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

**Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)**

Policies, etc., to be followed, and records

s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,

(b) is complied with.

The licensee has failed to ensure that the home's policy "Head Injury Routine" was complied with.

**Rationale and Summary**

A Resident required a Head Injury Routine (HIR) assessment. The staff initiated the HIR and completed the first assessment. The second, third, fourth, fifth and sixth time slots were not fully completed. The 16th time slot was not completed and was left blank. No progress notes were recorded to indicate that the staff attempted to complete the assessment.

During an interview with staff, they indicated that the resident would need to have the HIR fully completed.

Not ensuring that the HIR was completed placed the resident at risk due to a delay in treatment if the assessment indicated.

**Sources:** Review of the home's Head Injury Routine policy, last reviewed July 2024, Resident's clinical records and staff interviews.