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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 4, 2024
Inspection Number: 2024-1139-0004
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 Aurora, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 2-4, 2024

The following intake(s) were inspected:

- An intake related to the physical abuse of a resident by a staff
- An intake related to the fall of a resident resulting in a change in status

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with the home's zero tolerance for abuse policy. An incident of physical abuse involving a staff member towards a resident occurred, and the home's Registered Nurse (RN) and on-call manager were made aware of the incident. The staff member involved in the incident continued to provide care for the remainder of their shift.

Sources: Polices, Critical Incident Report (CIR), internal investigation notes, and interview with Director of Care (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.

The licensee has failed to immediately report a staff to resident physical abuse incident that occurred on a specific date, and the CIR was submitted a day after the incident. The DOC confirmed that staff failed to immediately inform the Director of the staff to resident abuse incident.

Sources: Policies, CIR, and interview with DOC.

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) (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;

The licensee has failed to ensure that the identified altered skin integrity for a resident was reassessed on a weekly basis. An initial assessment of the altered skin integrity was completed on specific date, but no further reassessments were completed.

Sources: Skin and Wound Assessments and interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 6.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee failed to ensure adequate access to PPE (Personal Protective Equipment), specifically all sizes of gloves, for residents requiring Additional Precautions on a specified Resident Home Area (RHA) on a specific date. During an observation of the specified RHA, it was observed that several residents were on Additional Precautions and not all sizes of gloves were available at the point of care. RPN #104 was unable to locate a specific size of gloves on the unit. The specific size of gloves were located in the basement storage room but there was a delay in locating them. All sizes of gloves were not easily accessible to staff on the unit.

Sources: Observations, interviews with the IPAC Lead and RPN #104.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee failed to ensure that, at minimum, Additional Precautions include Additional PPE requirements including appropriate selection, application, removal, and disposal. A resident room was noted to have signage indicating that specific Additional Precautions were in place. The Additional Precautions provided instructions for disposal of PPE. PPE was observed to be disposed of incorrectly on a specific date.

Sources: Observations, interviews with PSW #101 and the IPAC Lead.