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
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Public Report

Report Issue Date: January 13, 2025

Inspection Number: 2025-1139-0001

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 Aurora, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7 to 10, and 13, 2025.

The following intake(s) were inspected:

- An intake related to improper care.
- An intake related to neglect of a resident.
- An intake related to skin and wound care and plan of care.
- An intake related to neglect of a resident, falls prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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 that the care set out in the plan of care for a resident was provided to the resident as specified in the plan, specifically related to bed mobility and personal care. On a specified date, a resident fell from their bed during personal care resulting in an injury that required a transfer to the hospital. The Executive Director (ED) confirmed that the staff did not follow the resident's plan of care.

Sources: Resident's clinical health records, the home's internal investigation notes and interview with the ED.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that a resident received a skin and wound assessment upon return from hospital on a specified date. The resident's clinical health records showed that a registered staff member did not complete a skin and wound assessment for a resident on their readmission to the LTCH from hospital. The skin and wound lead confirmed that a skin and wound assessment was not completed but should have been completed upon return from hospital.

Sources: Resident's clinical health records and interview with the skin and wound lead.

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 failed to ensure that resident's wound was reassessed at least weekly. A resident returned from hospital with a wound on a specified date and was not assessed until multiple days later when the wound condition worsened. Following the initial assessment, the resident's wound was not assessed weekly and was resolved with no formal skin and wound assessment to confirm resolution of the wound. The skin and wound lead confirmed that the wound should have been assessed weekly until healed and that this did not occur.

Sources: Resident's clinical health records and interview with the skin and wound lead.