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

Report Issue Date: November 15, 2023

Inspection Number: 2023-1141-0004

Inspection Type:
Complaint
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 Parkhill, Parkhill

Lead Inspector	**Inspector Digital Signature**
Tatiana Pyper (733564)	Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2023.11.24 08:45:34 -05'00'

Additional Inspector(s)
Christie Birch (740898)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2023 and November 1, 2, and 3, 2023
The inspection occurred offsite on the following date(s): November 6, 7, and 8, 2023

The following intake(s) were inspected:

- Intake: #00095634 - 2632-000015-23: related to fall preventions and management.
- Intake: #00096447 – complainant related to care and services, dining and snack services, and fall preventions and management.
- Intake: #00096826 - Follow-up #: 1 – Compliance Order O. Reg. 246/22 s. 53 (1) 1.
- Intake: #00099166 - related to nursing care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1141-0003 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Tatiana

Pyper (733564)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director related to the resident sustained a fall with injury. Resident had a history of multiple falls in the past quarter and was rated as a high risk for falls upon assessment.

In an interview with direct care staff, they stated the resident was at high risk for falls and required falls interventions. Direct care staff also stated the resident often removed their falls interventions that were put in place.

Review of the resident's care plan noted that the resident was at high risk for falls and required falls preventions interventions, and required a certain level of assistance with transfers.

Further observations noted the resident was in their room, without all their falls interventions in place. The signage on the wall of the resident's room indicated they were required to have falls interventions in place.

In an interview with the Administrator/Director of Care (Administrator/DOC), they stated the resident no longer required part of their falls interventions. They also stated resident does remove the falls interventions put in place for them.

There was risk to the resident related to inconsistent directions related to interventions for falls prevention and management.

Sources: Interview with Administrator/DOC and direct care staff, observations of the resident and resident's room, Record review of the CI, Point Click Care (PCC) records and signage in resident room.

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Date Remedy Implemented: November 3, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident and their substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) related to the resident's care needs not being respected and promoted.

Review of the resident's clinical records indicated that on one occasion resident was noted to not have their requested care devices in place.
Review of the resident's care plan indicated that they were not required to have a specific device in

place.

The resident's substitute decision maker stated that they had communicated to the home that the resident was to have these care devices in place.

Administrator/Director of Care (DOC) stated that at the time of inspection the resident's care plan did not reflect the substitute decision maker's request for care devices to be in place for the resident. Administrator/ DOC stated that they had updated the care plan for the resident to reflect resident's substitute decision-maker's wishes.

The lack of opportunity to participate fully in the development and implementation of the resident's plan of care impacted the resident's ability to receive proper care.

Sources: Review of clinical records for the resident, interview with substitute decision maker for the resident, and interview with Administrator/DOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

Review of the resident's clinical records indicated that there was an order in place for altered skin integrity treatment twice daily for a resident.

A review of the resident's Electronic Treatment Administration Record (eTAR) indicated that their skin treatment was not monitored for infection and changed twice daily on two occasions.
Review of the resident's plan of care indicated that they were to have their skin treatment twice daily.

In an interview, Administrator/DOC acknowledged that the resident's skin treatment was not monitored for infection and changed twice daily on two occasions.

Failure to provide the treatment to the resident as per the eTAR, put the resident at increased risk of

skin deterioration.

Sources: review of clinical records for the resident, interview with the resident, and Administrator/DOC.

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WRITTEN NOTIFICATION: Dining Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that a resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary

A complaint was reported to the Ministry of Long-Term Care (MLTC) regarding care concerns for a resident.

During the inspection at the home, resident was observed to have a meal served to them before someone was available to provide assistance with eating. Observations of meal service on two occasions, noted that staff members provided assistance with eating to the resident after they completed other meal services tasks.

Review of the resident's care plan indicated they required assistance with eating. Nutrition Manager stated that the home's expectation was that staff members were to cover the food with a food dome to ensure that the food stays warm until the feeding is completed.

There was risk that the resident’s meal could be cold and unpleasant when their meal had been served, but they were waiting for someone to come and provide the assistance they required.

Sources: Dining observations, record review for the resident, and interview with Nutrition Manager.

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