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

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Original Public Report

Report Issue Date: November 16, 2023	
Inspection Number: 2023-1403-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare London, London	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.11.16 15:47:16 -05'00'
Additional Inspector(s) Pauline Waldon (741071) Christie Birch (740898)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7, 8, 9 and 14, 2023.

The following intake(s) were inspected:

- Intake: #00100901 - Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 for a resident, was provided to the resident as specified in the plan.

Rationale and Summary:
A resident was assessed at high nutritional risk and required adaptive aids at meals. The plan of care under the eating focus and the servery Meal Service report in the dining room directed staff to provide the adaptive aids at meals.

During observation of a breakfast and lunch meal service, the resident had not received their adaptive aid as specified in the plan.

The Interim Director of Care (IDOC) and Registered Dietitian (RD) stated that the resident should have received the adaptive aids as it was listed in their care plan.

This placed the resident at nutritional risk as they were not receiving the interventions that were in place to help support their food and fluid intake.

Sources: Clinical records for a resident, including care plan and assessments, observations of a resident and interview with the IDOC and RD.
[524]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with. In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee must complete Infection Prevention and Control (IPAC) audits every week when a home is in outbreak.

The licensee has failed to ensure that IPAC self-audits were completed as required.

Rationale and Summary:
As per a Critical Incident System report (CIS), the home was in outbreak during a specific period of time and an IPAC self-audit was not completed every week.

The IPAC Lead acknowledged that the IPAC self-assessments were not completed as required.

By failing to complete the IPAC self-audits as required, there was risk that IPAC needs to manage the outbreak may have gone unnoticed.

Sources: IPAC Self-Audits, a CIS report, and interview with the IPAC Lead.
[741071]

WRITTEN NOTIFICATION: Doors in a Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

Rationale and Summary:
During the proactive compliance inspection(PCI), the door to the treatment rooms on two units were observed to be closed but not locked on two different dates.

Signage was observed on each door stating that the door was to be kept closed and locked at all times.

In an interview with two different registered staff members, they both stated they would expect the door to be locked and proceeded to lock the door.

There was risk to residents related to the access of this non-residential area by residents.

Sources: Observations, and interviews with staff members.
[740898]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to comply with the home's nutritional care and dietary services and hydration policy related to food temperature monitoring.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that written policies and procedures were developed for the nutritional care and dietary services and hydration program, and that they were complied with. Specifically, staff did not comply with the licensee's "Food Temperature," policy last revised January 2023.

Rationale and Summary:
The home's "Food Temperature" policy stated in part, that the food temperature would be taken before meal service to residents to ensure that food was maintained at a safe temperature. The Food Service Worker would take and record food temperatures once food has been placed in the steam table, on the Food Temperature Sheet.

During observation of a lunch meal service, Inspector #524 reviewed the Food Temperature Sheet in a servery at point of service. The food temperatures had not been recorded prior to meal service for breakfast and lunch.

A staff member said that they would normally place the food in the steam table and take the temperatures before meal service and record in the book, however, they had not taken them. The Nutrition Manager stated the home's expectation was that food temperatures were taken and recorded at point of service to verify the temperatures of the food served.

There was an increased risk that food would be served to residents at unsafe temperatures when food temperatures were not taken or recorded.

Sources: Meal observation, "Food Temperature" policy No: LTC-CA-WQ-300-04-02 revision date January 2023, and interviews with the Nutrition Manager and other staff.
[524]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure that resident lifts were cleaned and disinfected between resident use.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee was required to have procedures developed and implemented for the cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs, and that they were complied with. Specifically, staff did not comply with the licensee's "Cleaning, Disinfection and Sterilization" policy last revised January 2023.

Rationale and Summary:
The home's "Cleaning, Disinfection and Sterilization" policy stated that all used equipment should be cleaned and disinfected as soon as possible after use and definitely prior to use by or for another resident.

A staff member acknowledged that they did not clean the lifts between resident use, unless the residents were on additional precautions.

There was risk of disease transmission by failing to clean and disinfect the lifts between resident use.

Sources: "Cleaning, Disinfection and Sterilization" policy No: LTC-CA-WQ-205-02-01 last revised January 2023, and interview with staff.
[741071]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)

The licensee has failed to ensure that the home's written plan for responding to infectious disease outbreaks was followed, specifically where staff were required to complete a polymerase chain reaction (PCR) test for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a written plan for responding to infectious disease outbreaks, and that it was complied with. Specifically, staff did not comply with the licensee's "Outbreak Management" policy last revised August 2023.

Rationale and Summary:
The Line List indicated that a resident became symptomatic of an infection and received a rapid antigen test (RAT).

The homes "Outbreak Management" policy stated that a resident meeting a specific case definition would be tested with a PCR swab for Coronavirus disease 2019 (Covid-19) and other infections.

The IPAC lead stated that a PCR was to be completed at the same time as a RAT and acknowledged that a PCR should have been done and was not completed for the resident.

There was risk that a resident's illness was not detected when the PCR was not completed as required.

Sources: Line List, "Outbreak Management" policy No: LTC-CA-ON-205-04-03 last revised August 2023, and interview with the IPAC Lead.
[741071]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that a resident's symptoms were recorded on every shift.

Rationale and Summary:
A resident became symptomatic of an infection on a specific date.

The IPAC lead stated the registered staff were expected to complete the Daily Infection Surveillance Tracking form and document a progress note related to the resident's signs and symptoms of infection including vital signs every shift.

In a review of the resident's progress notes, there was no documentation related to the resident's signs and symptoms for multiple days. Vital signs including temperature readings were also not recorded in the vital signs records in Point Click Care (PCC) or in the progress notes for multiple days. In addition, there was no documentation for numerous shifts on the Daily Infection Surveillance Tracking form.

By failing to record the resident's symptoms every shift, the resident's illness progression may not have been monitored effectively, potentially leading to a delay in treatment.

Sources: a resident's clinical records, the Daily Infection Surveillance Tracking form, and interview with the IPAC Lead.

[741071]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that the medication cart was secured and locked.

Rationale and Summary:
A registered staff member was observed to leave the medication cart in the hallway and enter resident rooms to administer medications without locking the medication cart on eight separate occasions. The same staff member was observed to leave the medication cart unlocked in the hallway and porter a resident down the hallway. In addition, the registered staff was also observed to leave the medication cart unlocked in the hallway while they walked the length of the hallway looking for a staff member, returning to the unlocked medication cart after three minutes.

The Interim Director of Care (IDOC) stated that registered staff were expected to lock the medication cart prior to leaving the cart unattended and acknowledged that the medication cart was left unsecured when the registered staff left the cart unlocked to enter the residents' rooms and walk down the hallway.

There was risk that a resident could have accessed the medication cart when it was left unlocked and unsecured.

Sources: Observations of a registered staff member, and interview with the IDOC.
[741071]