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: May 31, 2024

Inspection Number: 2024-1403-0001

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 London, London

Lead Inspector	**Inspector Digital Signature**
Janis Shkilnyk (706119)	Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2024.06.07 10:09:04 -04'00'

Additional Inspector(s)
JanetM Evans (659)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14-17, 21-24, 2024

The following intake(s) were inspected:

- Intake: #00096439 -related to a resident fall with injury
- Intake: #00099224 -related to a resident fall with injury
- Intake: #00102425- allegation of improper treatment/care of a resident
- Intake: #00108910 - complaint allegation related to care concerns of a resident
- Intake: #00111805 - Complainant allegation related to resident abuse
- Intake: #00115319 - related a missing resident

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to reassess a resident when their care needs changed.

Rationale and Summary:

A resident had interventions for a specific type of transfer need.

The resident's care needs changed, and they were not reassessed.

The resident sustained an injury when the interventions did not change.

Sources:

Interviews with staff, review of the resident's clinical records, policy LTC-CA-BC-ON-200-07-12 policy, Mechanical Lifts and Resident Transfers, revised July 2023

[706119]

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 was provided to a resident as specified in the plan.

Rationale and Summary

The resident received an item they were allergic to.

Failure to follow the resident's plan of care related to the resident's allergies put the resident at risk for an allergic reaction.

Sources:

plan of care, progress notes, home's investigation, interviews with Director of Care (DOC) and staff

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WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to update the plan of care for a resident when fall prevention strategies were not effective.

Rationale and Summary:

The resident was at high risk for falls.

They had several falls during a specific time period.

The plan of care for the resident had not been updated with new strategies for fall prevention or to address fall risk until after they sustained an injury.

DOC #101 acknowledged the resident's plan of care had not been updated when current interventions were not effective.

Failure to update the resident's plan of care when existing interventions were not effective was a missed opportunity to trial new strategies to prevent further falls or injury to the resident.

Sources:

plan of care, resident record review, interviews with DOC and staff.

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 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 their policy to promote zero tolerance of

abuse, when they did not follow the home's policy for investigating and responding to an allegation of improper or incompetent treatment or care of a resident.

Rationale and Summary

The home began an investigation into an allegation of improper and/or incompetent treatment of care of a resident.

The home's policy, Investigations, LTC-CA-WQ-100-05-01, revised September 2023, documented a written report would be completed of all investigations conducted by the Home. The policy referenced an investigation form template to be used. Issues requiring investigation included reportable incidents.

The home did not use the investigation form template that included names of those involved, written statements from those involved, nature of the concern, outcome of the investigation, immediate action taken, or further actions required.

The Director of Care (DOC) was unable to provide the home's investigation documentation related to the incident.

The home's failure to follow their abuse allegation, follow up and investigation policy related to an allegation of improper care and treatment may have led to risk for the resident by not investigating all aspects of the alleged allegations towards the resident and future analysis of the incident.

Sources:

interview with DOC, resident clinical records, critical incident summary, Policy No: LTC_CA_WQ_100-05-01, revised September 2023, Investigations, LTC-CA-

WQ_100-09-19 Investigation Form

[706119]

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that interventions and the resident's responses to interventions were documented.

Rationale and Summary

Interventions for a resident were to be documented.

There was missing documentation over a period of time on various interventions for the resident.

Staff stated that point of care (POC) documentation for interventions for each resident should be completed by the end of shift.

By not documenting interventions completed for a resident, care may not have been completed or care needs missed, posing a risk to the resident.

Sources:

Interviews with staff, review of clinical records, Flow sheet policy, LTC-CA_WQ_100-03-03. Revised April 2017

[706119]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to comply with safe lift and transfer techniques when a resident was transferred and sustained an injury.

Rationale and Summary

A resident was injured while being transferred.

The Arjo Sara 3000 sit to stand instruction manual, KKX52180M-EN-23 documented that a resident should be positioned in a specific manner while the caregiver lifted them.

Staff stated that during the transfer the resident was not positioned in a specific manner as required.

When staff did not use correct techniques during a transfer, the resident was injured.

Sources:

Resident clinical record, interview with staff, Arjo Sara 3000 sit to stand instruction manual , KKX52180M-EN-23

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WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to implement their falls prevention and management program related to a resident.

The home's Resident Falls Prevention program stated the program was to provide direction and guidelines to the interdisciplinary team. The program included use of a specific risk scale.

If a resident scored a specific number on the scale, they were to be referred to the physician for possible medical intervention. A resident score was taken and required this referral to be completed. It was not done.

The Director of Care (DOC) #101 stated they did not see any physician referral related to this or medical orders to be implemented.

When the home did not refer to the physician for possible medical interventions for a resident there was potential risk of missed opportunities for treatment.

Sources:

Physician PCC order summary, physician notes, nurse practitioner (NP) notes and interview with DOC, review of resident clinical record

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WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale an Summary:

A resident had an alternation to their skin integrity.

A clinically appropriate assessment instrument was not used to assess the resident.

The Skin and Wound nurse and Director of Care (DOC) #101 acknowledged an initial skin and wound assessment was not documented for the resident and it should have been.

Failure to record an initial skin and wound assessment using a clinically appropriate assessment instrument may risk their ability for follow up or timely treatment interventions if require.

Sources:

Resident clinical records, interviews with staff, skin and wound policy

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WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 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 a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident's area of altered skin integrity was

reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

A resident had an area of altered skin integrity identified.

There was no weekly skin assessment completed for the area.

The Skin and Wound Lead and DOC acknowledged there was no assessment completed and said that a skin assessment should have been completed under the assessment tab in PCC.

Sources:

Plan of care, skin and wound assessments, interviews with DOC and Skin and Wound lead.

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WRITTEN NOTIFICATION: Retention of resident records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 276 (2)
Retention of resident records
s. 276 (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home.

The licensee failed to ensure the resident's records were retained in the home.

A deceased residents clinical chart was requested by inspector 659.

The home was unable to provide the hard copy clinical records when requested.

The Director of Care (DOC) #101 stated they had been unable to locate the resident's hard copy records.

Sources:

interviews with DOC and Receptionist/unit clerk

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