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 8, 2024

Inspection Number: 2024-1403-0004

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 29, 31, 2024 and November 1, 4, 5, 7, 2024
The inspection occurred offsite on the following date(s): October 30, 2024
The following intake(s) were inspected:

- Intake: #00122311 - a complaint related to responsive behaviours
- Intake: #00124014/ CIS 2919-000041-24 related to resident to resident abuse
- Intake: #00124192/ CIS 2919-000043-24 related to an allegation of neglect
- Intake: #00126440/ CIS 2919-000046-24 related to an allegation of neglect

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

Continence Care
Resident Care and Support Services

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Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

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)
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 safety devices in a resident's plan of care were used as specified in the plan.

Summary and Rationale
The Ministry of Long Term Care received a complaint related to safety concerns for a resident.

Interventions related to safety were included in the resident's plan of care.

Inspectors observed on multiple occasions that the safety interventions were not in place for the resident.

The Behavioural Support Ontario (BSO) Lead confirmed what interventions that were in place in the plan of care for the resident and said they should be followed. The

Executive Director (ED) stated the plan of care interventions were to be followed and used properly.

There was a low risk of harm to the resident as a result of the interventions not being in place as per the plan of care.

Sources: clinical records for resident, observations of resident room and interviews with the ED, BSO Lead and other staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that two residents, who required continence care products had sufficient changes to remain clean, dry, and comfortable.

Summary and Rationale
The home submitted a Critical Incident System (CIS) report to the Director related to an incident where two residents, who used incontinence products, were found saturated in urine by staff.

The home's investigation determined that two Personal Support Workers (PSWs) did not complete continence care as per the expectations of the home.

The Director of Care (DOC) said that residents and did not receive adequate changes of their incontinence products to remain clean, dry, and comfortable. There was a risk of harm the resident's skin integrity and comfort when the residents were not provided with adequate changes.

Sources: Clinical records for two residents, the home's investigation notes, job routines, and interviews with the DOC and other staff.