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

Public Report

Report Issue Date: February 25, 2025

Inspection Number: 2025-1403-0002

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 dates: February 10-12, 14 and 18, 2025.
The inspection occurred offsite on the following dates: February 13, and 19, 2025.
The following intake(s) were inspected:

- Intake #00135025/Critical Incident System Report (CIS) #2919-000051-24 related to allegations of improper care of a resident
- Intake #00135101 related to allegations of neglect of a resident
- Intake #00135363 related to allegations of neglect of a resident, plan of care of a resident
- Intake #00136087/CIS #2919-000001-25 related to fall prevention and management
- Intake #00138522/CIS #2919-000005-25 related to allegations of abuse of a resident
- Intake #00138980/CIS #2919-000006-25 related to allegations of abuse of a resident

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff for the use of their device.

From January to February 2025, clear direction was not provided to the staff on the proper usage of a resident's device resulting in areas of altered skin integrity.

Sources: Critical Incident System Reports, Clinical records for a resident, Interviews with staff #123, staff #124 and staff #126.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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

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

A) A Resident had poor oral intake and staff were alerted on several days in November and December 2024. A referral was not made to the Registered Dietitian (RD) when the residents care needs changed, therefore no assessment was completed related to their poor oral intake.

B) A Resident had a significant change in November 2024, and a referral was made to the RD who asked for a reassessment of the resident. Registered nursing staff did not follow up with the RD when the RD had not reviewed the reassessment after it was completed.

C) A Resident had a significant change in condition in November and December 2024, when the resident 's transfer status changed. When the resident's condition changed and their transfer status changed, staff did not make a referral to physiotherapy for an assessment.

Sources: Review of resident clinical records, Home area (assessment) Tracking

Record 2024, the home's "Weights and Heights" policy LTC-ON-200-03-07 revised July 2024, the home's "Physiotherapy Services" policy LTC-ON-100-06-09 revised July 2024, the home's "Dietary Referral" policy LTC-ON-300-05-02 revised August 2024; and interviews with staff #122, staff #105, staff #116, staff #109 and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that allegations of abuse to five residents by a resident were immediately reported to the Director.

Allegations of abuse by a resident to two residents in November 2024 were not reported to the Director. Critical Incident Systems Report (CIS) detailed allegations of abuse to three residents in January 2025 by a resident, which was delayed in being reported to the Director. CIS detailed allegations of abuse to a resident in February 2025, by a resident, which was also delayed in being reported to the Director. Staff #117 acknowledged that all allegations of abuse should have been immediately reported to the Director, but were not.

Sources: CIS Reports, Clinical records for resident, the home's policy Reporting Certain Matters-Mandatory Reporting (Policy LTC-ON-100-05-04), and an interview with staff #117.

WRITTEN NOTIFICATION: Required Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
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:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions was developed and implemented in the home.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the skin and wound care program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Skin and Wound Care Program" LTC-ON 200-08-01 revised April 2024, when a resident who had a change in condition and was at risk for developing altered skin integrity, developed altered skin integrity to their lower extremities when staff did not develop a plan of care to maintain skin integrity and prevent skin breakdown.

Sources: Review of resident clinical records, the home's "Skin and Wound Care Program" LTC-ON 200-08-01 revised April 2024; and interviews with staff#105, and other staff.

WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions and the resident was started on an as needed medication in December 2024, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Sources: Review of resident clinical records, the home's "Pain Management Program" Policy LTC_ON-200-05-06 revised July 2024; and interviews with staff #105, and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident began demonstrating responsive behaviours, actions were taken to respond to the needs of the resident including assessments, reassessments and interventions and also that the resident's responses to the interventions were documented.

A resident began demonstrating responsive behaviours in October 2024. The resident's care plan did not include interventions related to the demonstrated behaviours until January 2025.

Furthermore, five behaviour assessment tools conducted between January and February 2025 for the resident who demonstrated responsive behaviours were not completed as per the expectations of the home.

In addition, the home's behaviour-specific policy indicated that a meeting should have been held with the spouse/partner or Power of Attorney (POA)/Substitute Decision Maker (SDM) of a resident expressing specified responsive behaviours and that a behaviour-specific assessment should have been completed. This meeting and assessment were not completed until February 2025, four months after the specified behaviours were first documented.

Staff #105 acknowledged that staff did not complete the behaviour assessments as per the expectations of the home and that the behaviour-specific assessment should have been completed sooner.

Sources: Clinical records for resident , behaviour assessments, the home's policy regarding behaviour-specific expressions, and interviews with the staff #105 and other staff.

WRITTEN NOTIFICATION: Maintenance Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that pagers, identified in interviews with the staff #117 and staff #120 as functional components of the resident-staff communication and response system, have been kept in good repair on two neighbourhoods. It was noted in an interview with PSW #102, and during observations of two home areas in February 2025, that staff did not have access to any working pagers to ensure a timely response to resident requests for assistance.

Sources: Observations of two neighbourhoods; Interviews with staff #102, #117, #120; and record review of LTCH policy Resident Safety - Systems and Rounds

WRITTEN NOTIFICATION: Police notification

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the police were immediately notified of incidents of alleged abuse of five residents by a resident.

The home submitted Critical Incident System (CIS) reports to the Director, which detailed incidents of alleged abuse by the resident to three residents in January 2025. A review of the clinical records detailed further incidents of alleged abuse by the resident to two other residents in November 2024.

Staff #117 stated that the police were not immediately notified of any of these allegations of resident to resident abuse.

Sources: Clinical records for residents, the home's policy Titled ""Abuse Allegation and Follow-Up" (LTC-ON-100-05-02, Revised July 2024), Critical Incident System (CIS) reports to the Director and Interviews with staff #117 and other staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Protect residents from abuse by the resident.

B) Ensure the home continues to use one to one staff to monitor the resident during the noted shift or as per the assessed requirement for the resident.

Grounds

The licensee has failed to ensure that five residents were protected from abuse by a resident.

The home submitted Critical Incident System (CIS) reports to the Director, which detailed incidents of alleged abuse by the resident to five residents in January and February 2025.

A review of the clinical records detailed further incidents of abuse by the resident two residents in November 2024, which involved non-consensual acts, and which were not investigated by the home or reported to the Director.

There was a risk to residents due to lack of action taken by the home after the initial incidents. There was also an impact to residents as a result of these incidents as residents did not or could not consent to the action with the resident and staff noted that some residents avoided or expressed fear in the presence of the resident.

Sources: Clinical records for residents, the home's policy Titled "Abuse Free Communities-Prevention, Education, and Analysis" (LTC-ON-100-05-01 Revised July 2024), the home's investigation notes, CIS reports to the Director, observations, and interviews with staff #117 and other staff.

This order must be complied with by March 14, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the past 36 months, a CO under FLTCA, 2021 s. 24 (1) was issued once (2022-1403-0001)

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Ensure all members of the Registered Nursing Staff, who work regularly on the affected home area are retrained on the home's policy of zero tolerance of abuse and neglect, including assessments to complete after an allegation of abuse, notification of the Power of Attorney (POA), notification of the appropriate manager, and documentation of the incident and notifications. A record must be kept of the date the training was provided, who attended the training, the contents of the training, and who provided the training.

B) Ensure that a specific resident's POA was or is informed of the incident of abuse that was documented in November 2024. A record must be kept of when the notification was made, who made the notification, and any concerns noted by the POA.

Grounds

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with regarding five residents.

Specifically, the licensee failed to ensure that staff complied with the home's policy titled "Abuse Allegation and Follow-Up" (LTC-ON-100-05-02, Revised July 2024), which stated that when a staff member received a report or observed abuse of a resident that they were to immediately notify the Executive Director, Director of Care (DOC) or building Supervisor/Manager on

Duty. Also following an allegation of a specified abuse, staff were to complete and document a head-to toe physical assessment and immediately notify the resident's Substitute Decision Maker (SDM) and/or Power of Attorney POA).

After two allegations of abuse to two residents by a resident in November 2024, there was no documentation of a head to toe skin assessment, notification of the POA and/or manager.

After three allegations of abuse to three residents by a resident in January 2025, there was no documentation of a head to toe skin assessment, notification of the POA and/or manager.

There was a risk to residents when there was no documented head to toe assessment or notification of applicable manager or POA, or applicable managers completed after incidents of alleged abuse.

Sources: Clinical records for residents, the home's policy titled "Abuse Allegation and Follow-Up" (LTC-ON-100-05-02, Revised July 2024), and interviews with staff #117 and other staff.

This order must be complied with by March 14, 2025

COMPLIANCE ORDER CO #003 Licensee must investigate, respond and act

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Acting together as a team including a representative from the AgeCare Corporation, the Director of Care, Assistant Director of Care, and Executive Director must conduct a review of the allegations of abuse of two residents by a resident in November 2024. This review must be documented and address any deficiencies from the time of the incidents related to the home's policies for zero tolerance of abuse and investigations.

B) Retrain the Director of Care and Assistant Director of Care on the home's policy related to internal investigations. Ensure AgeCare corporate oversees and conducts the training in person. Documentation must be kept of the dates the training was completed, who conducted the training, and the material reviewed during the training.

Grounds

The licensee has failed to ensure that incidents or allegations of abuse to five residents by a resident were immediately investigated.

The home submitted Critical Incident System (CIS) reports to the Director, which detailed incidents of abuse by a resident to three residents in January 2025. No records of immediate investigation related to these incidents were provided to Inspectors, with the earliest investigation notes dated late January 2025.

Review of clinical records also identified incidents of abuse from a resident to two residents in November 2024. Staff #117 acknowledged that these allegations of abuse were not investigated by the home.

There was a risk to resident safety when witnessed or alleged incidents of abuse were not immediately investigated.

Sources: Clinical records for residents, the home's policies titled "Abuse Free Communities-Prevention, Education, and Analysis" (LTC-ON-100-05-01 Revised July 2024) and "Investigations" (LTC-ON-100-05-03 Revised July 2024), the home's investigation notes, CIS reports to the Director, and interviews with staff #117 and other staff.

This order must be complied with by March 14, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.