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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 9, 2024

Inspection Number: 2024-1298-0001

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 Pine Grove, Woodbridge

Lead Inspector	**Inspector Digital Signature**
Oraldeen Brown (698)	Oraldeen Brown Digitally signed by Oraldeen Brown Date: 2024.02.28 21:48:16 -05'00'

Additional Inspector(s)
Ann McGregor (000704)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23, 24, 25, 26, 29, 30, 31, 2024.

The following intake(s) were inspected:

- Intake #00099223, Critical Incident System (CIS) report #2808-000029-23 related to allegations of abuse.
- Intake #00099734, CIS report #2808-000032-23 related to neglect.
- Intake: #00099616, CIS #2808-000031-23 and #00102014, CIS #2808-000033-23 related to outbreaks.

The following complaint intake was inspected:

- Intake: #00103917 related to allegations of sedation and theft.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

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 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other, in the assessment of a resident so that their assessments were integrated and were consistent with and complemented each other.

Summary and Rationale
The Inspector observed a resident's who had evidence of altered skin condition as a result of a past injury.

An RPN acknowledged that they were made aware of the resident's altered skin condition. An assessment was completed but did they did not refer the resident to be seen by the physician for further examination.

The DOC acknowledged that a referral was not sent to the physician for the resident to be assessed regarding altered skin condition and that the resident should have been referred to the physician for further assessments.

Sources: The resident's observations, the resident's electronic health records and paper chart, interviews with the RPN and other relevant staff.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for a resident.

Rationale and Summary
A resident's Substitute Decision Maker (SDM) informed the inspector that the resident had sustained an injury.

The home was notified by the resident's SDM of the injury.

The DOC was immediately made aware by the resident's SDM.

The resident's electronic records did not indicate any documentation by the DOC regarding the SDM's concerns nor any actions taken by the DOC or any other staff members.

An RPN acknowledged that they were made aware of the resident's injury. They completed their assessments but did not document their actions using the home's assessment tools.
The DOC also acknowledged that they too, did not document their observations, nor their directions to the staff regarding the resident's injury. They acknowledged that they and the RPN did not document any assessments completed for the resident's injury.

Failure of the home to document the provision of care set out in the plan of care may have contributed to increased health risk to the resident.

Sources: The resident's electronic health records, interview with the RPN and the DOC.

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WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the

report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to ensure that where a licensee was required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) related to disease outbreak.

The CIS was submitted after regular business hours. However, the home did not use the Ministry's method for after-hours emergency contact.

The DOC acknowledged that they were aware of the requirements and did not report using the Ministry's method for after-hours emergency contact.

Failure to call the after-hours line within the appropriate timeline did not place residents at risk.

Sources: CIS # 2808-000033-23 and interview with DOC.

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