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: April 11, 2024	
Inspection Number: 2024-1298-0002	
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 Pine Grove, Woodbridge	
Lead Inspector Chinonye Nwankpa (000715)	**Inspector Digital Signature** Chinonye Nwankpa Digitally signed by Chinonye Nwankpa Date: 2024.04.16 18:23:10 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 5 - 8, 11 - 13, and 25, 2024, with March 27-28, 2024, conducted off-site.

The following intake(s) were completed in this complaint inspection:

- Intake: #00107906 was related to allegation of abuse and neglect.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00105866/CI #2808-000001-24 was related to fall of a resident resulting in injury.
- Intake: #00107772/CI #2808-000004-24 was related to alleged improper care and injury of unknown cause.

- Intake: #00108172/CI #2808-000005-24 was related to alleged abuse and neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident had a fall which resulted in an injury.

The home's Resident Falls Prevention policy noted that a specific assessment was to be completed by the registered staff before a resident is moved after a fall.

The home's investigation notes showed that after the resident fell, Personal Support Workers (PSWs) transferred the resident before the specific assessment was completed by the registered staff.

The PSWs and the Registered Nurse (RN) acknowledged the specific assessment was not completed as per the home's policy.

Failure to complete the specific assessment before transferring the resident placed them at risk for injury.

Sources: Resident's clinical records, the home's investigation notes, Resident Falls Prevention Policy; interviews with the PSWs, RPN and RN. [000715]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning of the resident when they required assistance.

Rationale and Summary
A review of a record revealed that a resident was fed fluids in an unsafe position by a PSW and a Registered Practical Nurse (RPN).

The home's LTC Care Staff Guidebook noted that residents are to be fed in a specific position.

The Director of Care (DOC) acknowledged that the PSW and RPN both fed the resident in an unsafe position.

When staff fed the resident in an unsafe position, it increased their risk of aspirating.

Sources: Resident's clinical records, video recorded footage, the home's LTC Care Staff Guidebook; interviews with the DOC. [000715]

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 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:

1. Conduct an audit to ensure a that a specific device is always within the reach of a resident. This audit should be done at a minimum three times a week on evening and night shifts, for a period of three weeks following

service of this order.

2. Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, staff audited, outcome and actions taken as a result of any deficiencies identified.

3. Educate all PSWs and registered staff (RPNs and RNs), including agency staff on specified resident home area(s):

- The home's policies on prevention of abuse and neglect
- The home's policies on responding to residents exhibiting responsive behaviours
- The Residents' Bill of Rights set out in s. 3 of the FLTCA and the Fundamental Principle as set out in s. 2 of the FLTCA.
- Definitions of the types of abuse, along with examples of emotional and physical abuse as noted in the grounds of this Compliance Order, ways to identify and prevent abuse in the home, and power imbalances as described in s. 103 (e) (i) of O. Reg. 246/22.

4). Maintain a record of the education, including the content, date, signatures of staff members who attended and the staff member who provided the education.

Grounds

The licensee has failed to ensure that a resident was protected from physical and emotional abuse by staff.

Rationale and Summary

For the purpose of the Act and the Regulation:

- "Physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

- "Emotional" abuse means any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

1) A review of video records showed a resident was physically abused by a PSW.

The home's investigation notes indicated that the resident reported the incident and pain they experienced as a result.

The DOC acknowledged that the resident was physically abused by the PSW during care.

Failure to protect the resident from physical abuse increased their risk of injury and pain.

Sources: Resident's clinical records, video footage, the home's investigation notes; interview with the DOC. [000715]

2) A review of video records showed a resident was emotionally abused by PSWs when they interacted with the resident.

The resident's clinical records indicated that they expressed concerns about their care.

The DOC acknowledged that the PSWs interactions with the resident were inappropriate.

Failure to protect the resident from emotional abuse increased their risk of harm and distress.

Sources: Resident's clinical records, video footage, the home's investigation notes; interview with the DOC. [000715]

3) A review of video records showed a resident was emotionally abused by PSWs when they removed a specific device from the resident's reach.

The resident clinical records revealed that the resident verbalized concerns about their care.

The DOC acknowledged the specific device had been removed from the resident's reach and was not easily accessible to them.

Removing the specific device from the resident's reach placed them at risk of experiencing social isolation.

Sources: Resident's clinical records, video footage, the home's investigation notes; interview with the DOC. [000715]

This order must be complied with by May 20, 2024

COMPLIANCE ORDER CO #002 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Conduct an audit to ensure that a resident's specific fall management intervention is implemented as specified in their plan, at a minimum three times a week on each shift (day, evening, and night), for a period of three weeks following service of this order.

2) Conduct an audit of specific continence interventions for a resident as specified in their plan, including the level of assistance required for continence interventions, at a minimum three times a week on each shift (day, evening, and night), for a period of three weeks following service of this order.

3) Maintain a record of the audits completed, including but not limited to, date of audit, person completing the audit, unit audited, staff and resident audited, their care plan effective during the time of the audit, audit outcome and actions taken because of any deficiencies identified.

4) Educate all PSWs and registered staff (RPNs and RNs), including agency staff on specified resident home area(s):
    - The home's expectations on adhering to the care plan of residents and the potential risks associated with non-adherence.
    - The home's toileting and continence care policies

5) Maintain a record of the education, including the content, date, signatures of staff members who attended and the staff member who provided the education.

Grounds

The licensee has failed to ensure that the care set out in plan of care of specific residents was provided to them as specified in their plans.

Rationale and Summary

1) A resident's care plan stated they required a specific device as part of their fall prevention interventions.

The resident's clinical records revealed the specific device was not applied when they experienced a fall.

An interview with PSWs confirmed that the resident's care plan was not followed.

Failure to apply the device as specified in their plan of care placed the resident at increased risk of injury.

Sources: Resident's clinical records; interviews with the PSWs. [000715]

2) A resident's care plan stated they required a specific continence care intervention. The home's investigation notes showed that the resident did not receive the specified continence intervention at the frequency indicated in their care plan.

A PSW and the DOC acknowledged the resident's care plan was not followed.

There was increased risk to the resident when the staff failed to provide the continence care intervention as specified in their care plan.

Sources: Resident's care plan, the home's investigation notes; interviews with the PSW and DOC. [000715]

3) A resident sustained an injury of unknown cause.

The resident's care plan stated they required a specific care intervention. The home's investigation notes showed that the PSWs who discovered the resident's injury did not provide the care intervention as specified in the resident's care plan.

A PSW, Physiotherapist (PT) and the DOC acknowledged the care was not provided to the resident as specified in their care plan.

Failing to provide the care intervention as specified in the resident's care plan increased their risk of injury.

Sources: Resident's clinical records, the home's investigation notes; interviews with the PSW, PT and the DOC. [000715]

This order must be complied with by June 6, 2024

COMPLIANCE ORDER CO #003 Transferring and positioning techniques

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate all PSWS and registered staff including agency staff, on the home's Zero Lift policy, on transferring a resident post fall, procedures for staff when

a resident has fallen, and the home's transferring and repositioning techniques and devices by the compliance due date of this order.

2. Maintain a record of the education, including the content, date, signatures of staff who attended and the staff member who provided the education.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when they assisted residents.

Rationale and Summary
1) A resident experienced a fall resulting in an injury.

The home's Resident Falls Prevention policy noted that a specific device must be used for resident transfers post-fall unless the resident was able to stand with minimal assistance from staff, and the transfer should be overseen by the nurse in case an injury was not determined during the initial assessment. Furthermore, the home's Resident Transfers and Lifts policy noted that there was a "Zero Manual Lift" protocol in place, which meant that staff were not permitted to physically lift or transfer residents.

The home's investigation notes showed that after they fell, PSWs transferred the resident without the specific device.

The PSWs acknowledged that they performed the transfer without a nurse present, and that no device was used. A RN noted that the transfer of the resident without the specific device was unsafe and against the home's policy.

There was an increased risk of worsening the resident's injury when the staff performed an unsafe transfer.

Sources: Resident's clinical records, the home's investigation notes, Transfers and Lifts Policy, Resident Falls Prevention Policy; interviews with the PSWs and RN. [000715]

2) A resident sustained an injury following a fall.

The home's LTC Care Staff Guidebook directed staff to use a specific repositioning device. However, the video records showed a PSW repositioned the resident without the specific device.

The DOC acknowledged that the staff used an unsafe positioning technique and failed to use the repositioning device as per the home's policy.

There was an increased risk of injury to the resident when the staff failed to use the repositioning device.

Sources: Resident's clinical records, video footage, the home's LTC Care Staff Guidebook; interview with the DOC. [000715]

3) A resident was transferred using an unsafe device when the resident experienced a change in condition.

The home's policies stated that before each lift or transfer, the care staff were to observe the resident's ability and any significant changes, and they were to inform the registered staff of these changes prior to performing the activity.

The home's investigation notes revealed that when PSWs identified a change in the resident's condition, they did not inform the nurse and they proceeded to transfer the resident with a specific device.

The PT indicated that the transfer with the specific device became unsafe for the resident when their condition changed. A PSW acknowledged that they should have informed the nurse before transferring the resident when they initially identified a change in their condition.

There was risk of worsened injury when staff performed an unsafe transfer.

Sources: Resident's clinical records, Mechanical Lifts and Resident Transfers LTC, the home's investigation notes; interviews with the PSW and PT. [000715]

This order must be complied with by June 6, 2024

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