Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: March 18, 2024	
Inspection Number: 2024-1383-0001	
Inspection Type: 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 Trilogy, Scarborough	
Lead Inspector Matthew Chiu (565)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-7, 11, and 13, 2024.

The following intake(s) were inspected:

- #00105347, #00106207, and #00109515 related to infectious disease outbreaks.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard for long-term care homes, revised September 2023, was implemented in accordance with the standard. Specifically:
- Routine practices section 9.1 (d), directed the home to ensure proper use of personal protective equipment (PPE), including appropriate selection, application, removal and disposal.

Rationale and Summary:
A resident was placed under droplet and contact precautions due to an infection. During a shift, a Registered Practical Nurse (RPN) was observed providing care to the resident within their room. The RPN failed to wear the necessary PPE, entering the room and providing care to the resident. The IPAC lead confirmed the importance of wearing the necessary PPE when providing care to the resident and acknowledged the staff member failed to do so.

The non-compliance posed a risk of transmission of infectious agents and potentially leading to further spread within the home.

Sources: Observation; resident's progress notes; interviews with the RPN, IPAC Lead, and DOC.
[565]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection were recorded for a resident.

Rationale and Summary:
Record review and staff interviews revealed that a resident was placed under droplet and contact precautions after they began demonstrating symptoms indicating the presence of infection. The IPAC lead indicated that staff were required to monitor the resident's symptoms of infection during every shift and document them in Point Click Care (PCC). However, it was confirmed that there was no documentation of the resident's symptoms on seven identified shifts, as required.

Failure to record symptoms of infection every shift caused a risk of ineffective care planning and potential of delayed interventions for the resident.

Sources: Resident's progress notes, assessment records; interviews with the IPAC

lead and DOC.
[565]