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 Licensee Report

Report Issue Date: May 31, 2024
Inspection Number: 2024-1383-0002
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 Trilogy, Scarborough
Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 27, 28, 29, 2024.

The following intake(s) were inspected:

- Intake: #00112836 - Critical Incident Systems (CIS) #2899-000004-24 - Allegation of neglect of a resident
- Intake: #00115058 and 00115161 - Complaints related to allegations of neglect and improper care of a resident

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to comply with the policies and procedures developed to address nutritional care.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is the development and implementation of policies and procedures relating to nutritional care and must be complied with.

Specifically, staff did not comply with the policy "Food and Fluid Intake", dated June 2023, which was included in the licensee's Nutrition and Hydration Program.

Rationale and Summary

A complaint was forwarded to the Ministry of Long-Term Care (MLTC) related to an allegation of staff's failure to provide adequate nutritional care to resident #001.

A review of Point of Care (POC) documentation indicated that from the evening of March 27, 2024 to April 1, 2024, the resident had either eaten 50% or less of their meals or had refused their entire meal. The progress notes also indicated that from March 27, 2024 to April 1, 2024, various staff documented on the days and evening shift that the resident ate 50% or less or refused their meals and snacks and the resident's substitute decision maker (SDM) was informed.

A referral to the Registered Dietitian (RD) was completed on April 1, 2024, addressing the resident's decreased intake. The home's Food and Fluid Intake policy indicates that a referral to the RD should be made when a resident has a reduced food intake of 50% or less for a period of three days or more.

Facility Charge Nurse (FCN) #103 stated that an eariler referral to the RD may have been beneficial to the resident's wellbeing, given their refusal of meals during that period. RD #102 stated that based on the documentation from the staff and the home's policy, a referral to the RD would have been required by March 31, 2024.

Failure to involve the RD eariler in assessing the resident may have led to missed opportunities for timely nutritional interventions.

Sources: Home's policy, titled "Food and Fluid Intake", dated June 2023; Review of POC, assessments and progress notes documentation; Interview with FCN #103, RD #102 and other staff. [760]