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

Public Report

Report Issue Date: November 20, 2024

Inspection Number: 2024-1383-0004

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2024 and November 1, 5-8, 2024

The following intake(s) were inspected in the Complaint Inspection:
Intake: #00128869 - Related to resident elopement, reporting, and a fall with injury

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:
Intake: #00128780 - 2899-000024-24 - Related to a missing resident
Intake: #00125038 - 2899-000017-24 - Related to a fall of a resident resulting in injury
Intake: #00128573 - 2899-000023-24 - Related to resident-resident physical abuse

The following intake(s) were completed in the CIS Inspection:
Intake: #00124968 - 2899-000016-24 - Related to a fall of a resident resulting in injury

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Intake: #00128461 - 2899-000021-24 - Related to a fall of a resident resulting in injury
Intake: #00125147 - 2899-000018-24 - Related to Infection Prevention and Control (IPAC)

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
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for its residents when a registered staff allowed a resident to leave a secure home area unaccompanied.

Rationale and Summary

A registered staff used their access card to allow a resident to leave a secure home area. The resident left the home area by themselves and eloped from the home.

The registered staff did not verify with the other staff on the unit if the resident should be allowed to leave alone. The registered staff assumed the resident was going downstairs but would be unable to exit the home without an access card and allowed the resident to exit the unit alone. The long-term care home (LTCH) was unaware that the resident had left the home until later that day, when the resident's family member informed the LTCH that they saw the resident on their residence's surveillance footage.

The registered staff, Facility Charge Nurse (FCN), and the Director of Care (DOC) confirmed that the registered staff should have consulted with the FCN or staff familiar with the resident's plan of care and should not have used their access card to allow the resident to leave the secure home area unaccompanied.

Failure of the licensee to ensure that the home was a safe and secure environment for its residents resulted in the resident eloping from the home.

Sources: The home's sign-out sheet, a resident 's clinical record, interview with the home's staff and management.

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

The license has failed to ensure the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident returned from the hospital with a medical device due to an injury. On a specified date, the resident removed the medical device. Clinical records indicated that the staff did not reapply the medical device as it was removed and refused by the resident. There were no records to indicate the resident's substitute decision maker (SDM) was notified until a specified date. The DOC indicated staff were expected to communicate with a resident's SDM when there were any changes to a resident's status or any resident refusals.

There was an increased risk of miscommunication between the home and the resident's SDM when the SDM was not notified by the home that the resident had removed the medical device in the appropriate timeframe.

Sources: Interview with the home's staff and management, a resident's clinical record.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident sustained a fall. The resident's clinical records indicated that they were unable to weight bear after the fall. A registered staff stated the resident was manually transferred from the ground to a chair with three-person assistance after their fall.

The home's Resident Falls Prevention Program policy stated that a mechanical lift must be used unless the resident was able to stand with minimal assistance from staff.

Failure to ensure that staff used safe transferring techniques when assisting the resident increased the risk of injury.

Sources: A resident's clinical records, the home's Resident Falls Prevention Program policy (LTC-CA-WA-200-07-08; last revised June 2022), interviews with the home's staff and management.