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: November 20, 2024
Inspection Number: 2024-1383-0003
Inspection Type: Proactive Compliance Inspection
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 17-18, 22-25, 28-31, 2024

The following intake(s) were inspected:
Intake: #00128944 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Air temperature

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.
Air temperature
s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

The licensee has failed to ensure that the temperature is measured and documented in writing, at a minimum, in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor.

Rationale and Summary

The home's air temperature log from between specified dates indicated there were several shifts that were missing air temperature recordings in at least one resident common area on all floors of the home.

The home failed to ensure that the air temperature is measured and documented in writing in one resident common area on every floor of the home, which may lead to the inability of the home to monitor the air temperature and implement appropriate

measures.

Sources: Air temperature records in the home, interview with Environmental Service Manager (ESM).

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's wound was reassessed at least weekly.

Rationale and Summary

A resident had a wound and their clinical records indicated that the last assessment was completed on a specified date.

The Skin and Wound Lead acknowledged that weekly assessments should have been completed for the resident.

There was a risk for delayed implementation of interventions for the resident when their weekly assessments were not completed.

Sources: A resident's clinical records and interview with the Skin and Wound Lead.

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, a clinically appropriate pain assessment tool was utilized.

Rationale and Summary

A resident was experiencing pain on a specified date. A registered staff administered medication to the resident, but they continued to experience significant pain. Another medication was administered by another registered staff member on the following shift; however, documentation continued to indicate that this was ineffective as the resident was still experiencing significant pain.

The resident's clinical records revealed no pain assessments were completed after the administration of both medications.

The Director of Care (DOC) acknowledged that the resident should have been reassessed using the comprehensive Pain Assessment tool when their pain was not managed by the initial interventions.

Failure to utilize a clinically appropriate pain assessment tool to further analyze the

root cause of the resident's pain may result in lost opportunities to implement effective interventions.

Sources: A resident's clinical records and interview with the DOC.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that cleaning and disinfection of contact surfaces was used in accordance with the manufacturer's specification and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

On a specified date, the Ecolab Multi-Surface Disinfectant used to clean and disinfect high-touch surfaces in the cleaning supplies storage room on the fifth floor was observed to have been past the expiry date.

The home's cleaning and disinfection policy stated that all disinfectant agents, including pre-prepared wipes, must have a drug identification number and must be used according to manufacturers' recommendations and according to the product's safety data sheet.

The Infection Prevention and Control (IPAC) Lead acknowledged that using expired disinfecting products would not be as effective as what was intended by the manufacturer, increasing the risk of the spread of infections and harmful pathogens.

Sources: Observation made on a specified date, home's policy on Cleaning, Disinfection and Sterilization (ALL-ON-205-02-01, revision approval date August 2024), and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, IPAC Standard for Long-Term Care Homes, s. 10.2 (c) and s. 9.1 (d) stated that the licensee shall ensure that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks; and that Routine Practices and Additional Precautions were followed in the

IPAC program. At minimum Additional Precautions shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary

(i) On a specified date, a staff member was observed providing a beverage to a resident. The staff member stated that they did not assist or offer hand hygiene assistance to the resident prior to serving the snack.

The IPAC Lead stated that residents should be assisted or offered with hand hygiene assistance before meals and snacks.

Failure to assist the resident with hand hygiene before snacks placed them at risk for acquiring infections.

Sources: Observation made on a specified date, interviews with the home's staff and management.

(ii) On a specified date, prior to exiting a resident room who was on contact precautions, a staff member was observed not completing hand hygiene after the removal of their gloves prior to removing their face masks.

The IPAC Lead verified that the staff member should have performed hand hygiene after doffing the gloves prior to removing their face masks.

Staff not doffing their PPEs according to the routine practices and in the appropriate order increased the risk of spreading infectious disease amongst residents, staff, and others.

Sources: Observation made on a specified date, interviews with the home's staff and

management.

WRITTEN NOTIFICATION: Quarterly evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that an interdisciplinary team that included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary

The home's last quarterly evaluation of the medication management system on a specified date indicated that the Administrator was not present for the evaluation.

The DOC verified that the Administrator did not participate in the evaluation.

There was a missed opportunity to have additional suggestions for improvement when the Administrator was not present for the quarterly evaluation.

Sources: The home's quarterly evaluation of the medication management system and interview with the DOC.

WRITTEN NOTIFICATION: CMOH and MOH

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed by the home in relation to alcohol-based hand rub (ABHR). Specifically, ABHR must not be expired as required by 3.1 IPAC Measures under Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

Rationale and Summary

On a specified date, the ABHR in several resident rooms on the seventh floor were noted to have been past their expiration date.

The IPAC Lead acknowledged that using expired ABHRs may result in ineffective disinfection, increasing the risk of the spread of infections and harmful pathogens.

Sources: Observation made on a specific date, and interview with the IPAC Lead.