

**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:** January 17, 2025

**Inspection Number:** 2025-1383-0001

**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): January 9-10, 13-17, 2025

The following intakes were inspected in the Complaint inspection:

- Intake: #00129855 – related to skin and wound care, allegations of neglect, continence care, and falls prevention;
- Intake: #00130624 – related to incompetent care, allegations of neglect, food, nutrition and hydration, palliative care;

The following intake was inspected in the Critical Incident (CI) inspection:

- Intake: #00135474/CI #2899-000047-24 related to falls with injury;
- Intake: #00126841/CI #2899-000046-24 related to disease outbreak.

The following intakes were completed in the Critical Incident (CI) inspection:

- Intake: #00133323/2899-000038-24 – related to falls with injury;
- Intake: #00129247/2899-000027-24 – related to falls with injury;
- Intake: #00129091/2899-000026-24 - related to falls with injury.

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

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Skin and Wound Prevention and Management  
Continence Care  
Resident Care and Support Services  
Housekeeping, Laundry and Maintenance Services  
Food, Nutrition and Hydration  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Palliative Care  
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of care

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

**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 licensee has failed to ensure that an intervention was in place for a resident, as specified in their plan of care. The resident was at risk of falls and required the above-mentioned intervention to mitigate the risk of falls.

**Sources:** Resident's clinical records; and Interviews with a Personal Support Worker (PSW).

### WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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**Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.**

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the garbage room door on a resident home area (RHA) was kept closed and locked when they not being supervised by staff.

On a particular date, it was observed that the garbage room door was left ajar and not supervised by staff. A second observation on another day, the same garbage room door was again left ajar.

**Sources:** Observation on a RHA, interview with Assistant Director of Care (ADOC), a PSW and the Environmental Service Manager (ESM).

**WRITTEN NOTIFICATION: Skin and wound care**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**

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,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

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The licensee has failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument when they were exhibiting new altered skin integrity. The resident was identified with wounds, however a skin and wound assessment was not completed in a timely manner.

**Sources:** Resident's skin and wound assessments and progress notes; Skin and Wound Program, LTC-ON-200-50-2 (Revised July 2024); and interviews with a Registered Nurse (RN) and the Skin and Wound Coordinator.

## WRITTEN NOTIFICATION: Skin and wound care

NC #004 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 altered skin integrity was reassessed at least weekly by a member of the registered staff. The weekly wound assessments were not completed as required.

**Sources:** Resident's skin and wound assessments; Skin and Wound Program, LTC-ON-200-50-2 (Revised July 2024); and interviews with a RPN and the Skin and Wound Coordinator.

## WRITTEN NOTIFICATION: Continence care and bowel management

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NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)**

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's plan of care was implemented to promote and manage bowel and bladder continence, when staff did not assist them with their assessed method of toileting as indicated in the plan.

**Sources:** Resident's care plan; and interviews with a PSW and other staff.

**WRITTEN NOTIFICATION: Infection prevention and control  
program**

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)**

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, resident's symptoms indicating the presence of infection were monitored during an outbreak. Failure of staff to monitor the residents' symptoms of infection every shift, placed the residents at risk of delayed treatment of their infection.

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**Sources:** Review of resident's clinical records; and interview with the IPAC Lead.

## **WRITTEN NOTIFICATION: Reports re critical incidents**

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an Acute Respiratory Illness (ARI) outbreak when it was declared by Toronto Public Health (TPH). A Critical Incident was submitted after business hours but no calls were made to the after-hours line.

**Source:** Critical incident report (CI) #2899-000046-24, and interview with the IPAC Lead and DOC.

## **COMPLIANCE ORDER CO #001 Infection prevention and control program**

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)**

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

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(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

**The inspector is ordering the licensee to comply with a Compliance Order  
[FLTCA, 2021, s. 155 (1) (a)]:**

Specifically, the licensee must:

1. Provide education to the nursing management, IPAC lead and registered staff in the LTCH home about the home's policy related to case definition and who meets that definition. Specifically, when to report suspected cases to the local Public Health Unit according to the home's policy
2. IPAC lead to conduct weekly audits for 4 weeks of all reported symptomatic residents to assess if they meet the case definition for a suspected outbreak and provide teaching where necessary.
3. Maintain written records of the audits completed and any additional teaching that was completed as a result of the audits. All written records must be available on request.
4. Maintain written records of the education provided, who provided the education and the list of all staff that received the education. All written records must be available on request.

**Grounds**

The licensee has failed to comply with the home's policy related to outbreak management system.

In accordance with O. Reg 246/22 s. 11 (1) (b), the home is required to have in place an outbreak management system for detecting, managing and controlling infectious

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disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act and must be complied with.

Specifically, staff did not comply with the policy "Outbreak Management," dated November 2024, which was included in the home's Infection Prevention and Control program.

On a certain date, there was an identified respiratory symptomatic resident on a RHA who was placed on Droplet Contact Precautions (DCP). The following day there were 2 additional residents with respiratory symptoms who met the case definition on the same unit. There were no reports made to the local Public Health Unit.

The Infection Prevention and Control (IPAC) Lead confirmed that the home did not report the initial cases to the local Public Health Unit but should have.

**Sources:**

Review of the home's outbreak line list, initial communication emails with the local Public Health Unit, home's "Outbreak Management" policy, dated November 2024, and interview with the IPAC lead.

**This order must be complied with by**

March 3, 2025



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## 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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

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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, 9<sup>th</sup> Floor

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**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
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438 University Avenue, 8<sup>th</sup> Floor  
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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).