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

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Public Report

Report Issue Date: March 13, 2025

Inspection Number: 2025-1383-0002

Inspection Type:
Complaint
Critical Incident
Follow up

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): March 4-7, 10-13, 2025.

The following intakes were inspected during this Critical Incident (CI) Inspection:
- Intake #00134182/ CI #2899-000044-24 was related to an allegation of resident-to-resident physical abuse.
- Intake: #00139500/ CI #2899-000004-25 was related to a disease outbreak.

The following Follow-up intakes were inspected:
- Intake #00137421 was related to Compliance Order (CO) #001 from inspection #2025-1383-0001.

The following Complaint intakes were inspected:
- Intake #00137073 was a complaint related to missing narcotics and medication management.

The following intakes were completed in this CI inspection:
- Intake #00137037/ CI #2899-000001-25 and Intake #00141442/ CI #2899-000007-25 were related to disease outbreaks.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1383-0001 related to O. Reg. 246/22, s. 102 (11) (a)

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from physical abuse by another resident.

Ontario Regulation (O. Reg.) 246/22, defines "physical abuse" as, (c) the use of physical force by a resident that causes physical injury to another resident.

A resident was demonstrating responsive behaviours, and struck two co-residents.

One of the co-residents sustained injury as a result.

Sources: Residents' clinical records, interview with staff.

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 (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 the implementation of a standard issued by the Director with respect to Infection Prevention and Control (IPAC). The home failed to ensure proper use of personal protective equipment (PPE), including appropriate application of PPE in accordance with the IPAC Standard as required by Additional Precaution 9.1(d) under the Standard.

An Essential Caregiver was observed without a gown and gloves while assisting a resident with feeding in their room, who was on additional precautions.

Sources: Observations, review of "IPAC Standard for Long-Term Care Homes, revised September 2023", interview with the Essential Care Giver and the IPAC Lead.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
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 the symptoms of three residents were documented during various shifts, when these residents showed signs of infection and were placed on additional precautions.

Sources: Review of residents' clinical records, interview with the IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
3. A missing or unaccounted for controlled substance.

The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance for a resident, no later than one business day after the occurrence of the incident. The Director of Care (DOC) stated that a critical incident report was not submitted related to the incident.

Sources: Interview with the DOC.

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the the written policies and protocols developed for the medication management system. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the Medication Management program were complied with.

a) Specifically, the home's Medication Incidents and Adverse Drug Reactions policy indicated that registered staff were responsible to complete and document in a resident's progress notes, when the medication incident was discovered and reported on a specified date, which did not occur.

Sources: Resident's progress notes; home's policy "Medication Incidents and Adverse Drug Reactions, LTC-ON-200-06-13" (Last revised July 2024); and interview with the DOC.

b) Specifically, the home's Controlled Medications policy indicated that registered staff going off shift and registered staff coming on shift would count and sign for narcotics and controlled substances at each shift change, in addition to documenting the name of the person administering the drug to the resident, date and time of administration, and dosage administered on the individual count sheet, which did not occur for a resident on specific dates.

Sources: Resident's controlled medication count records; Shift Change Monitored Medication Count Record; home's policy, Controlled Medications, LTC-ON-200-06-07 (Last Revised July 2024); and interviews with staff.