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**
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# Public Report

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| **Report Issue Date:** April 25, 2025 |
| **Inspection Number:** 2025-1383-0003 |
| **Inspection Type:**<br>Complaint<br>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 dates: April 15-17, 22, 24, 25, 2025

The following intakes were inspected:

- Intake: #00141497 – Complaint regarding skin and wound care, dining and snack service and continence care and bowel management
- Intake: #00141742 – Critical Incident (CI) #2899-000008-25 – related to neglect of a resident
- Intake: #00143982 – CI #2899-000009-25 – related to a disease outbreak

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

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

Resident Charges and Trust Accounts

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)**
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident, who exhibited altered skin integrity, received immediate treatment and interventions to reduce pain, promote healing and prevent infection.

A resident was admitted and an admission skin assessment indicated their skin was intact. However, a few days later, it was discovered the resident had been admitted with skin alterations. The Director of Care (DOC) acknowledged the resident's skin integrity was not properly assessed and immediately treated upon admission.

Sources: A resident's clinical record including progress notes and images/photos and interviews with a Registered Practical Nurse (RPN) and the DOC. [501]

## WRITTEN NOTIFICATION: Infection prevention and control

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 that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

(i) In accordance with Additional Requirement 9.1 (e) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), point-of-care signage was not in place for a resident.

A resident was on additional precautions but signage was not posted on the resident's door. An RPN and the IPAC Lead confirmed that additional precautions signage should have been placed on the door.

Sources: An observation and interviews with an RPN and the IPAC Lead. [000760]

(ii) In accordance with Additional Requirement 9.1 (f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), a caregiver did not don required Personal Protective Equipment (PPE) according to additional precautions which includes the appropriate selection and application of PPE.

A resident was on additional precautions and a caregiver was not wearing gloves while assisting the resident. The IPAC Lead confirmed that the caregiver should have worn gloves.

Sources: An observation and an interview with the IPAC Lead. [000760]

## WRITTEN NOTIFICATION: Infection prevention and control

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 symptoms for two residents were recorded on each shift when they were diagnosed with an infectious disease.

Symptoms for two residents were not documented in their progress notes on a specific shift while the residents were actively exhibiting symptoms and on isolation precautions. The IPAC Lead confirmed that symptoms were not recorded on each shift for both residents.

Sources: The residents' progress notes and an interview with IPAC Lead. [000760]