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: September 17, 2025
Inspection Number: 2025-1383-0006
Inspection Type: 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): September 8, 9, 11, 12, 15-17, 2025

The following Critical Incident System (CIS) intake(s) were inspected:

- Intake: #00154976 – [CIS: 2899-000024-25] – Resident to resident physical abuse
- Intake: #00155312 – [CIS: 2899-000025-25] – Resident to resident physical abuse
- Intake: #00156127 – [CIS: 2899-000027-25] – Staff to resident physical abuse

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that a Registered Practical Nurse (RPN) complied with the home's written policy to promote zero tolerance of abuse.

The home's policy stated that when a staff member observes another staff member abusing a resident, they will separate the resident and the abuser, immediately report the incident to a Manager on Duty and speak privately with the alleged abuser indicating the inappropriate actions and document the conversation.

A RPN witnessed a Personal Support Worker (PSW) hit a resident. The RPN did not report this incident until several days later during which time the PSW continued to work with the resident.

Sources: The home's policy #LTC-ON-100-05-02 titled "Abuse Allegation and Follow-up" last revised July 2024 and interviews with a RPN and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee had failed to ensure a RPN who had reasonable grounds to suspect a PSW abused a resident immediately reported their suspicions to the Director. In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Homes Act. pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

A RPN witnessed a PSW hit a resident. The RPN did not report this incident to anyone until several days later when they told a Facility Charge Nurse who then reported to the Director.

The DOC confirmed there was reasonable grounds to suspect abuse which should have been reported to the Director.

Sources: The home's investigation notes and an interview with the DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours, that strategies were implemented to respond to these behaviours.

Resident #001 had an intervention in place to monitor and manage their responsive behaviours. Resident #001 was demonstrating responsive behaviours and had a physical altercation with resident #003. The intervention was not in place at the time of the incident.

Sources: Resident #001's clinical records; home's investigation notes; and interviews with Behavioural Support Ontario (BSO) RPN, a RPN and ADOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Create a case study scenario of the incident of witnessed emotional abuse focusing on identifying measures and strategies to prevent such abuse.
2. Conduct an in-person review of the case study with all direct care staff.
3. In the review, present strategies for staff to respond to residents demonstrating responsive behaviours, including gentle persuasive approach.
4. Maintain the records of the above discussions including the content of the case study, date of the review, name of staff who provided the review, and staff signed attendance.
5. Review and evaluate the effectiveness of the licensee's current zero tolerance of abuse and neglect training, specifically related to physical and emotional abuse.
6. Maintain a written record of the evaluation, including the date of the review, the name of staff who completed the evaluation, and identify any areas for improvement.

Grounds

i) The licensee has failed to ensure a resident was protected from emotional abuse by a PSW.

Section 2 (1) of the Ontario Regulation defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

A RPN witnessed a PSW hit a resident. According to the RPN, the resident appeared fearful but had no noticeable physical injury.

Failing to protect the resident from emotional abuse resulted in fearfulness.

Sources: Critical Incident (CI) # CI 2899-000027-25; the home's investigation notes and an interview with a RPN.

The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #001.

Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

ii) Residents #001 and #002 had a physical altercation. A RPN witnessed resident #001 hitting and kicking resident #002, resulting in an injury.

Resident #002 stated they were hit and scratched by resident #001. The RPN and Assistant Director of Care (ADOC) confirmed that resident #001 caused physical injury to resident #002.

Failure to protect resident #002 from physical abuse by resident #001 resulted in injury to resident #002.

Sources: Resident #001 and #002’s clinical records; home’s investigation notes; and interviews with resident #002, a RPN and ADOC.

iii) Residents #001 and #003 had a physical altercation, resulting in resident #003 sustaining an injury.

Resident #003 stated that resident #001 used force during the altercation, causing injury. A RPN confirmed that resident #001 caused physical injury to resident #003.

Failure to protect resident #003 from physical abuse by resident #001 resulted in injury to resident #003.

Sources: Resident #001 and #003’s clinical records; home’s investigation notes; and interviews with resident #003, a RPN, and other staff.

This order must be complied with by October 29, 2025

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, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.