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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 23, 2024	
Inspection Number: 2023-1423-0005	
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 Royal Oak, Kingsville	
Lead Inspector Jennifer Bertolin (740915)	**Inspector Digital Signature** Jennifer Bertolin Digitally signed by Jennifer Bertolin Date: 2024.01.29 13:14:00 -05'00'
Additional Inspector(s) Julie D'Alessandro (739) Adriana Congi (000751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3-5, 8, 2024.
The inspection occurred offsite on the following date(s): January 4, 5, 8, 2024.
The following intake(s) were inspected:

- Intake: #00100029- [Critical Incident (CI): 2939-000047-23]: Resident Care and Support Services
  Intake: #00100278 - [CI: 2939-000048-23]: Fall Prevention and Management
- Intake: #00102957- [CI: 2939-000058-23]: Resident Care and Support Services

The following intakes were completed in this inspection:
Intake: #00097873 and Intake: #00097461 were related to fall prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
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

Duty of licensee to comply with plan

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.

Introduction:

The licensee failed to ensure that a direct care staff member provided care to a resident as outlined in their plan of care.

Summary and Rationale:

A progress note in Point Click Care (PCC) on a specific date and time indicated that a resident was to have had two staff for all care, a direct care staff member attempted to change the resident alone, and the resident had rolled off the bed in the process.

A review of the resident's plan of care, indicated that the resident was to be provided total assistance with continence care and dressing by two staff.

During an interview with a registered staff member and a direct care staff member,

they stated that the direct care staff member provided care to the resident by themselves, and the resident was to have two staff members for care.

During an interview with the home's management team member, they acknowledged that the resident should have been provided care by two staff and was not.

Sources: The resident progress notes and plan of care as well as interviews with staff, and the home's management team.
[739]

WRITTEN NOTIFICATION: Weekly Skin and Wound Assessments

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 a member of the registered nursing staff, if clinically indicated.

Introduction:
The licensee failed to ensure that the resident's altered skin integrity was re-assessed weekly by a member of the registered staff using a clinically appropriate assessment instrument.

Summary and Rationale:
An initial skin and wound assessment was completed in PCC on a specific date, for the resident which had indicated that there was an area of altered skin integrity.

Upon review of the weekly skin alteration assessment in PCC there was a full assessment of the altered skin integrity completed on a specific date, which showed that there were physical changes to the altered skin integrity, and another assessment was not completed.

During an interview with the home's management team member they acknowledged that the resident's altered skin integrity was not re-assessed weekly by a member of the registered staff using a clinically appropriate assessment instrument.

Sources: The resident's initial skin and wound assessment and weekly wound assessment documentation in PCC as well as an interview with a management team member.
[739]

WRITTEN NOTIFICATION: Resident Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274 (b) the resident's written record is kept up to date at all times.

Introduction
The licensee failed to ensure that a resident's written record was kept up to date.

Rationale and Summary
Review of the resident's progress notes in PCC indicated that they were discovered unresponsive on a specific date and time. The resident was pronounced deceased at a specific time by the registered nurse.

Review of the resident's task and interventions documentation in Point of Care (POC), showed there was no documentation completed to indicate that care was provided to the resident on day shift.

During an interview with a direct care staff member, they stated that they were working on the resident's unit on a specific date. According to the direct care staff member, they and their coworker did not document on the resident because they had not provided care to the resident on that specific date.

During an interview with the two of the home's management team members, they acknowledged that staff should have completed documentation for the resident even if care had not been provided.

Lack of documentation on the resident compromises the quality and safety of care.

Sources: Staff Interviews, Progress Notes, and Task/Interventions Report

[740915]

COMPLIANCE ORDER CO #001 Safe Positioning

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

-The Director of Care (DOC) or designate shall perform two audits per week by observing personal care provided by the Personal Support Worker (PSW) involved with the critical incident, to residents who require two staff for care, to ensure that residents are positioned and provided care as per their plan of care. These audits must be documented, including the date, resident name, and the staff member who completed the audit, and actions made based on audit results until April 4, 2024.

Introduction:

The licensee failed to ensure that the PSW used safe positioning techniques when assisting the resident with continence care.

Summary and Rationale:

A progress note in PCC dated on a specific date and time indicated that the PSW attempted to change the resident and the resident rolled off the bed and hit their head on the floor. The progress notes also stated that the bed was at working height, roughly two and a half to three feet from the floor. The resident sustained an altered skin integrity to their head and was sent to hospital for further intervention.

A progress note dated for a specific date, indicated that the resident received diagnostic images of a certain body parts which showed injuries.

A review of the resident 's plan of care, indicated that the resident was to be provided total assistance with continence care by two staff to promote safety.

During interviews with a registered staff member and a PSW they stated that the PSW provided care to the resident by themselves when the resident rolled out of bed.

During an interview with the home's management team member, they acknowledged that the resident should have been provided care by two staff for safety and was not.

Sources: Resident's progress notes and plan of care as well as staff and management interviews.
[739]

This order must be complied with by April 4, 2024

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.