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

Central East District
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Original Public Report

Report Issue Date: January 30, 2024	
Inspection Number: 2024-1139-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Aurora, Aurora	
Lead Inspector Nicole Lemieux (721709)	**Inspector Digital Signature** Nicole S Lemieux Digitally signed by Nicole S Lemieux Date: 2024.02.14 11:17:54 -05'00'
Additional Inspector(s) Vernon Abellera (741751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10 to 12, and 15 to 18, 2024.

The following intake(s) were inspected:

- One intake related to a Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that medication management policies and protocols, specifically related to medication administration, were implemented.

Rationale and Summary

Medication administration process was observed as part of the Proactive Compliance Inspection (PCI). During the observation, a registered staff completing the medication pass showed the Inspector a paper cup that had medications in it. These medications were removed from a resident's medication bin in the

medication cart. During the medication pass, the registered staff confirmed the medications in the paper cup were prepared prior to starting the medication pass. The registered staff further confirmed that they had removed the one of the medications in the morning and the second medication prior to the lunch service. The home's Medication Administration policy stated that staff were not to pre-pour medications, to pour one, give one, sign for one then move on to another resident. The Director of Care (DOC) confirmed that pouring medication in advance was not the home's process and confirmed that the registered staff did not implement the policies and protocols related to medication administration.

Failing to implement the policy related to medication administration, specifically pre-pouring medications, put the resident as risk for receiving the wrong medication and dosage.

Sources: Observations, a resident's clinical records, the home's Medication Administration policy, interviews with staff and the DOC. [721709]

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee failed to ensure that a controlled substance was stored in a separate locked area within the locked medication cart.

Rationale and Summary

Medication administration process was observed as part of the PCI. During the observation, a registered staff completing the medication pass showed the Inspector a paper cup that had medications in it. These medications were noted to be removed from a resident's medication bin in the medication cart. The registered staff confirmed that they had stored the medications, specifically a controlled substance, in the resident's medication caddy in the medication cart and not the separate locked area within the medication cart. The home's Medication Administration policy stated that controlled substances were to be stored in a separate locked compartment of the medication cart in the locked medication room. The DOC confirmed that the registered staff did not follow the home's process and that the observed controlled substance should have been stored in the separate area in the medication cart.

Failing to ensure controlled substances were stored in a separate locked area within the locked medication cart increased the risk for the medication being removed without the nurse's knowledge.

Sources: Observations, the home's Medication Administration policy, interviews with staff and the DOC. [721709]

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) (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 failed to ensure that on every shift, symptoms indicating the presence of infection in a resident were monitored in accordance with any standard or protocol issued by the Director.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (LTCH) issued by the Director, updated September 2023, section 3.1 (b) states that the licensee shall ensure that surveillance is performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

A resident was symptomatic and was diagnosed with an infection. Progress notes for the resident confirmed that the resident was not monitored for signs and symptoms of infection for two shifts during the review period. The IPAC lead acknowledged that monitoring for signs and symptoms of infection were to be documented in a resident's progress notes every shift. Furthermore, the IPAC lead acknowledged that the resident was not monitored every shift for signs and symptoms of infection and that there should have been documentation every shift in the resident's progress notes.

Failure to monitor the resident's infectious symptoms every shift increased the risk of an unidentified worsening condition for the resident.

Sources: A resident's clinical records, interview with the IPAC lead. [721709]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in

accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber.

Rationale and Summary

Medication administration process was observed as part of the PCI. During the observation, a registered staff opened the medication cart and removed several medication pouches from a resident's medication caddy. The registered staff confirmed during the observation that they were administering medications from a previous medication pass. The registered staff showed the Inspector several medications from a previous medication pass that were being given as they were missed previously. The home's Medication Administration policy further indicates that the Registered Staff are to administer medications and treatment as ordered by the physician. The DOC confirmed that the medications were not administered as prescribed by the physician.

Failure to administer medications to the resident in accordance with directions for use specified by the prescriber posed a risk to the resident to experience an adverse reaction.

Sources: Observations, a resident's clinical records, the home's Medication Administration policy, interviews with staff and the DOC. [721709]