

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: June 13, 2025

Inspection Number: 2025-1139-0004

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 Aurora, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10-11 and June 13, 2025

The following intake(s) were inspected:

- An intake related to the fall of a resident with a change in health status.

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

- Infection Prevention and Control
- Reporting and Complaints
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports Re Critical Incidents

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District

33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

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):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

On a specified date, a resident experienced a fall with injury which resulted in a significant change in the resident's health status. The Director received notification of the incident a specified number of days after the event.

Sources: clinical records. Ministry of Long Term-Care Info Line After Hours report.

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Central East District

33 King Street West, 4th Floor

Oshawa, ON, L1H 1A1

Telephone: (844) 231-5702