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

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Public Report

Report Issue Date: August 7, 2025
Inspection Number: 2025-1234-0003
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 Aylmer, Aylmer

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 5, 6, 7, 2025

The following intake(s) were inspected:

- Intake: #00152261 - CI 2740-000016-25 Respiratory Outbreak.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 were monitored in accordance with any standard or protocol issued by the Director under subsection (2).
For reference, the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022, Revised September 2023, Item 3 noted "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"

The home was in an outbreak and documentation in the progress notes of Point Click Care (PCC) noted that this resident had symptoms of infection and was isolated. There were several shifts with no documentation in the resident's clinical records of assessment or monitoring of symptoms of infection during this time of isolation.

The Infection Prevention and Control (IPAC) lead confirmed that the home's expectation is that the registered staff would assess, monitor and document symptoms of infection on every shift in the progress notes of PCC and that had not been done consistently for this resident.

Sources: Review of resident's clinical records, the Critical Incident(CI), the Outbreak

Line Listing and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed, of the respiratory outbreak declared by Public Health.

The home was declared in a respiratory outbreak and did not complete the critical incident, which informs the Director, until the following day.

Sources: Review of the Critical Incident, the Outbreak line list and the Outbreak meeting minutes, and interviews with IPAC Lead.