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

Public Report

Report Issue Date: April 7, 2026
Inspection Number: 2026-1234-0002
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 Aylmer, Aylmer

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 23-27, 30, 2026 and April 1-2, 7, 2026

The following intake(s) were inspected:

- Intake: #00171004 - Customized Proactive Compliance Inspection (cPCI)

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

Skin and Wound Prevention and Management
Medication 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 home's Medication Orders Policy required the staff to document telephone orders on the Physician Order Form in the resident's chart, and the physician/nurse practitioner to sign the order upon their next visit to the home. The written policies and protocols for the home's medication management system were not implemented in accordance with evidence-based practices, when the medication management audits completed by the home documented that telephone orders for a resident were not signed by the physician.

Sources: Review of clinical records, Medication Order Policy, interview with the Assistant Director of Care.

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.

During observations of the locked medication rooms in the home areas with

controlled substances, that required refrigeration, were not secured with a double-lock as required.

Sources: Medication room observations.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 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).

A Medication was not administered in accordance with the directions for use by the prescriber when a resident was administered medication crushed which was not specified in the order.

Sources: Medication pass observations, review of resident clinical records, interview with Registered Nurse.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of

unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

A medication incident related to severe, unresponsive hypoglycemia that required glucagon was not reviewed and analyzed.

Sources. Review of Medication Incident reports, interview with Assistant Director of Care.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(i) reduce and prevent medication incidents and adverse drug reactions,
(ii) improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia;

A quarterly review of medication incidents did not include an incident of severe /

unresponsive hypoglycemia.

Sources: Review of **Medication Incident Review, interview with Assistant Director of Care.**

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 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)]:
The Licensee shall:
1. Hold a care conference with the interdisciplinary team to review all aspects of the resident's care. Attendees must include a member of the internal Behavioural Supports Ontario (BSO) team, a Manager of Resident Care, a member of the Skin and Wound Care team, a Registered Dietitian, the physician, and any other applicable interdisciplinary team members. Ensure that the resident and the resident's substitute decision-maker are given an opportunity to participate fully in the conference.

a. Keep a documented record in the resident's electronic health record of the care conference that includes the date, the participants, and the results of the care conference.

b. Complete a review of the resident's care plan following the care conference and

update the care plan with any recommended changes.

2. Complete a re-assessment related to responsive behaviours exhibited by the resident to identify triggers, strategies and interventions.

a. Implement and trial techniques and interventions to prevent, minimize or respond to the responsive behaviours.

b. Re-educate all Personal Support Workers and Registered Staff on the home area who provide care for the resident on the updated responsive behaviors section of the resident's care plan.

c. Maintain a documented record of how the re-education was provided, the staff educated and the date of education.

3. Complete daily checks to ensure that the resident's wound healing aid is in good working order.

4. Ensure the resident's food and fluid intake, bath and skin assessment refusals are documented, and reattempts are made and documented.

a. Re-educate all Personal Support Workers on the the home area who provide care for the resident on the PSW's responsibilities specific to skin care monitoring.

b. Re-educate all Registered Staff on the the home area who provide care for the resident on the registered staff responsibilities specific to skin assessment and monitoring.

c. Maintain a documented record of how the re-education was provided, the staff

educated and the date of education.

Grounds

A resident was not protected from neglect when the resident had demonstrated responsive behaviors related to refusing care that were not followed by the internal Behavioural Support Ontario (BSO) team, and staff did not apply interventions to respond to refusal of care that likely contributed to a decline in the resident's health.

Section 7 of Ontario Regulation 246/22 defines neglect as the failure to provide a resident with the treatment, care, services, or assistance required for their health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

A resident's care plan identified resistance to care, including refusing food and fluids, care, treatments, and self isolating behaviours, such as refusing to attend the dining room, declining to go to bed, and remaining in their mobility device for extended periods of time. The resident's care plan also identified they required the use of a wound healing aid to prevent advanced wounds.

Documentation noted that the resident had decreased oral intake. The resident's clinical records indicated that they refused to go to bed and stayed in their mobility aid for an extended period of time. There was no documentation related to staff re-approaching the resident when they refused care, or application of any behaviour management interventions.

Multiple wounds were identified on the resident. The resident's wound healing aid was noted to not be employed properly. The resident's clinical records indicated that skin and wound treatments were not completed on four separate days as

required. Review of documented wound assessments noted that the resident's wound status deteriorated.

In an interview with the Assistant Director of Care (ADOC) they acknowledged the following:
-The resident required medical treatment related to poor nutritional intake.
-The resident's wound healing aid was found to not be employed properly or monitored for an extended period of time.
-The resident was unable to reposition themselves while in their mobility device, and were not repositioned by staff as required every two hours for seven days.
-Wound care was not provided on four separate days as required.

There was no evidence of documented techniques or interventions to prevent, minimize, respond to, or reassess the resident's ongoing refusal of care for a resident. Persistent refusals of essential care were noted without demonstrated reassessment, reapproach, or coordinated response, resulting in unmet care needs and increased risk to a resident. The resident was not being actively followed by the internal Behavioural Supports Ontario (BSO) team.

Records did not demonstrate consistent re-approach, alternative hygiene measures, or follow-up, resulting in missed opportunities to complete required skin assessments when a resident refused their care. There was no evidence of consistent skin and wound assessments despite known risk factors, including poor nutritional intake and refusals of care.

Based on ongoing responsive behaviours, including the refusal of care, treatments, medications, assessments, oral intake, and no active involvement from the internal BSO team, there was high risk to a resident. Despite noted refusals, there was no evidence of alternative monitoring or reassessment which led to the limited ability

to identify a decline in health status. Delayed identification of advanced wound status placed the resident at an increased risk. The absence of interdisciplinary collaboration contributed to the unmet needs and neglect of a resident.

Sources: Review of a resident's clinical records, interview with a resident, staff and Assistant Director of Care.

This order must be complied with by June 15, 2026

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
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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

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.