Ontario

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

Inspection Report Under the Fixing Long-Term Care Act, 2021

London District
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London, ON, N6A 5R2
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Public Report

Report Issue Date: July 25, 2025
Inspection Number: 2025-1141-0004
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 Parkhill, Parkhill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23, 24, 25, 2025

The following intake(s) were inspected:

- Intake #00151785/ Critical Incident System #2632-000010-25 related to a Pathogen Outbreak.
- Intake #00152855/ Critical Incident System #2632-000012-25 related to improper care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: RIGHT TO QUALITY CARE AND SELF-DETERMINATION

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure a resident's right to proper care when the resident did not receive continence care in a timely manner.

Sources: Critical Incident System and staff interview.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a reportable incident was immediately reported to the Director.

Sources: Critical Incident System and staff interview.

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all Alcohol-based hand rubs in use were not expired.

Sources: Observation.