

**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**

<b>Report Issue Date:</b> October 15, 2025
<b>Inspection Number:</b> 2025-1141-0006
<b>Inspection Type:</b> Critical Incident
<b>Licensee:</b> Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.
<b>Long Term Care Home and City:</b> AgeCare Parkhill, Parkhill

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): October 6, 7, 8, 10, 14, and 15, 2025.

The following intake(s) were inspected:

- Intake: #00156319/Critical Incident System (CIS) report #2632-000017-25 related to resident neglect.
- Intake: #00157310/CIS #2632-000019-25 related to falls prevention and management.
- Intake: #00158904/CIS #2632-000022-25 related to an outbreak.

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Falls Prevention and Management

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Duty to Protect

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

**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 licensee has failed to protect a resident from neglect.

Staff members did not respond to a resident's care needs. The Interim Executive Director (ED) stated that everyone one working on the resident's home area was responsible to attend the resident's care needs.

**Sources:** Review of a CIS report, the resident's clinical record, employee files; and interviews with the resident, staff, the Interim Director of Care, and the Interim ED.

### WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 25 (1)**

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the

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policy is complied with.

The licensee has failed to ensure that the home's "Abuse Allegation And Follow-Up" policy was complied with.

The home's "Abuse Allegation And Follow-Up" policy stated documentation of an investigation was to be completed in accordance with AgeCare's applicable "Investigation" policy. The home's "Investigations" Policy stated that a written report would be completed of all investigations conducted by the home referring to the Investigation Template, and that written statements were to be obtained from all involved.

The Interim Executive Director (ED) investigated an incident of neglect but failed to formally document the investigation, including obtaining written statements from all involved.

**Sources:** Review of a Critical Incident System report, the home's Abuse Allegation And Follow-Up LTC-ON-100-05-02 revised July 2024, the home's "Investigations" Policy LTC-ON-100-05-03 revised July 2024; and an interview with the Interim ED.

## **WRITTEN NOTIFICATION: Required Programs**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

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The licensee has failed to ensure that the falls prevention and management program was implemented when a resident was not reassessed for falls risk after three falls.

In accordance with O. Reg 246/22, s.11 (1) (b), the licensee is required to ensure compliance with the home's "Falls Prevention and Management program" policy. The home's "Fall Prevention Program" policy indicated that as part of post fall management, the registered nursing staff should complete the Scott Fall Risk Assessment for residents with multiple falls, which means more than two falls in the previous six months.

A Critical Incident System (CIS) report was submitted by the home related to the fall of a resident that resulted in an injury.

The resident had seven additional falls in a six month period. A Scott Falls Risk Assessment was only completed for three of those falls. Therefore at the time of the fall where the resident sustained an injury, the resident had not had a Scott Falls Risk Assessment completed in four months and was not identified as a high risk for falls and had no falls interventions documented in their plan of care.

The Interim Director of Care (DOC) confirmed that the resident should have had a Scott Falls Risk Assessment completed after three of the falls due to a history of more than two falls in the previous six months and had not had that completed. The Interim DOC also confirmed that the resident was not identified as a high risk for falls and had not been discussed at the Falls Team meetings.

**Sources:** Observations of the resident; review of the resident's clinical record, CIS report #2632-000019-25 and the home's "Fall Prevention Program" Policy, # LTC-

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ON-200-05-03 revised July 2024; and interviews with staff and the Interim  
DOC/Falls Lead.

## **WRITTEN NOTIFICATION: Required Programs-Skin and Wound Care**

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)**

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an  
authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident who was at risk of altered skin  
integrity after returning to the home, received a skin assessment by a registered  
staff member.

A Critical Incident System (CIS) report was submitted by the home for a fall of a  
resident which resulted in an injury.

The Total Body Assessment of Skin and Wounds form was not completed until  
the following evening after the resident returned to the home and indicated the  
resident had several areas of altered skin integrity. There was no documented  
monitoring of the resident's altered skin integrity in Point Click Care (PCC) until two  
days after the resident returned to the home.

**Sources:** Review of the resident's clinical records, the CIS report, the home's Skin  
and Wound Program Policy, LTC-ON-200-05-02 revised March 2025; and

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interviews with staff and the Interim DOC.

## **WRITTEN NOTIFICATION: Infection Prevention and Control**

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

A) Section 9.1 (d) of the IPAC Standard for Long-Term Care Homes revised September 2023, states at a minimum Routine Practices shall include the proper use of Personal Protective Equipment (PPE), including the appropriate selection, application, removal, and disposal.

A staff member was observed not wearing their PPE appropriately.

B) Section 9.1 (e) of the IPAC Standard for Long-Term Care Homes revised September 2023, states at a minimum, Additional Precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place.

A resident was placed on additional precautions, but incorrect signage was placed on the door to the resident's room.

Personal Support Worker (PSW) #108, Registered Practical Nurse (RPN) #105

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were both aware of the type of additional precautions the resident was placed on. The IPAC Lead stated the correct signage had been posted on the resident's door and did not know why it had been changed.

**Sources:** IPAC observations in the home; review of the resident's clinical records, the home's "Routine Practices and Additional Precautions" policy #ALL-ON-205-03-07 revised August 2024, the home's "Personal Protection Equipment" policy #ALL-ON-205-03-05, revised August 2024; and interviews with the IPAC Lead and other staff.

## **WRITTEN NOTIFICATION: Screening Measures and Ongoing Declarations**

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)**

Hiring staff, accepting volunteers

s. 252 (2) The police record check must be,

(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

The licensee has failed to ensure that a police record check was conducted within six months before a staff member was hired.

A staff member was involved in an incident of neglect. A review of their employee file noted that there was no police record check on file that was conducted within six months before the staff member was hired.

**Sources:** Review of a Critical Incident System report, an employee file, the home's



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

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"Criminal Background Checks-Ontario LTC" policy LTC-ON-600-08-10 revised September 2024; and an interview with the Interim Executive Director.