

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: September 26, 2025
Inspection Number: 2025-1403-0007
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 London, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23, 24, 25, 26, 2025

The following intake(s) were inspected:

-Intake: #00156069 - CIS #2919-000040-25 related to Prevention of Abuse and Neglect.

-Intake: #00158096 - CIS #2919-000047-25 related to Resident Care and Support Services.

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

- Resident Care and Support Services
- Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident by a staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

During an interview with Director of care (DOC), they acknowledged that the allegation of abuse of the resident by staff was reported to the home management but it was not reported to the Director immediately.

Sources: review of email correspondence related to the alleged abuse of resident, and interview with DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home's "Routine Practices and Additional Precautions" policy stated that personal protective equipment, including eye protection was to be worn for residents who were on droplet and contact precautions.

A resident had additional precaution signage posted on their door. A staff member was observed entering the resident's room without wearing appropriate Personal Protective Equipment (PPE). Staff member stated they would only the appropriate PPE if a resident had COVID.

Sources: Observations of resident; review of resident's clinical record, and the home's "Routine Practices and Additional Precautions" policy ALL-ON-205-03-07 with a revision date of August 2024; and interviews with staff and the IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

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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 has failed to ensure that a resident who was experiencing signs and symptoms of infectious disease was monitored each shift.

The home's "Daily Infection Surveillance" policy stated registered staff would record infectious symptoms, the clinical assessment, and follow-up actions into a progress note in Point Click Care. Ongoing documentation during the course of the infection related to the resident status and actions taken, was to be completed in the progress notes each shift.

Resident experienced signs and symptoms of infectious disease but there were no progress notes that indicated the resident was monitored for signs and symptoms of infection at that time. When the resident was put in isolation, there were several shifts that monitoring of resident's symptoms was not documented.

Sources: Review of Critical Incident Systems (CIS) report #2919-000047-25, CIS report #2919-000043-25 , resident's clinical record, the home's "Daily Infection Surveillance" policy ALL-ON-205-03-02, revised November 2024 ; and interviews with Registered Practical Nurse and the Nurse Practitioner.