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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: March 25, 2026
Inspection Number: 2026-1423-0003
Inspection Type: Complaint 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 Royal Oak, Kingsville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17- 20, 23- 25, 2026

The following intake(s) were inspected:

- Intake: #00166069 CI# 2939-000089-25 related to the fall of resident
- Intake: #00167388 Complaint related to multiple care concerns for resident
- Intake: #00167468 CI# 2939-000005-26 related to the fall of resident
- Intake: #00168903 CI# 2939-000009-26 related to the fall of resident
- Intake: #00169563 CI #2939-000012-26 Alleged abuse of resident
- Intake: #00169711 CI# 2939-000013-26 Alleged abuse of resident
- Intake: #00172681 CI #2939-000023-26 Alleged abuse of resident

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

A) A Critical Incident was submitted by the home to the Director when a resident sustained an injury as a result of a fall. Specific resident's fall prevention interventions were not included in resident's plan of care. A Personal Support Worker and a Registered Nurse confirmed that resident's plan of care should encompass these interventions and they were unable to locate them in resident's clinical record.

Sources: resident's clinical record and interviews with staff

B) After an incident that occurred involving a resident, the Personal Support Worker Coordinator completed huddles with the unit staff noting that resident was to be monitored frequently while being toileted. A review of the resident's plan of care indicated that this requirement of the resident's planned toileting needs was not specified.

Sources: review of resident's records, Critical Incident and interview with the Personal Support Coordinator.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

Resident's plan of care did not provide clear directions to the staff related to resident's transfer and locomotion methods. A Registered Nurse confirmed the discrepancies between resident's care plan interventions and resident's methods transfer signs posted in the room and validated that these could be unclear for the staff on how to proceed.

Sources: resident's clinical record and interviews with staff

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A Critical Incident was sent to the Director related to the fall of a resident . Resident's care plan included an equipment to prevent injuries, however, the equipment was not provided to this resident. The Director of Care confirmed that the equipment should have been made available to them.

Sources**:** resident's clinical record and interviews with the staff.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A Critical Incident was submitted by the home to the Director due to a post-fall injury sustained by a resident. Resident utilized a fall prevention device that was not included in resident's plan of care. A Personal Support Worker and a Registered Practical Nurse indicated that this intervention should be have been incorporated in resident's clinical record, however, it was not.

Sources: resident's clinical chart and interview with staff

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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.

A) A staff member did not immediately report an allegation of abuse made regarding a resident to a manager, as required by the home's reporting policy. As a result, the allegation of abuse was not immediately reported to the Director.

Sources: Reporting Certain Matters - Mandatory Reporting Policy, interview with staff, resident's progress notes, and Critical Incident System Report

B) An allegation of neglect was not immediately reported to the Director. The allegation of neglect was reported as an e-mail to the home at a specific date. Furthermore, the Critical Incident System Report was not submitted to the Director in accordance with the required timeliness.

Sources: interview with staff and Critical Incident System Report review

WRITTEN NOTIFICATION: Accommodation Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

A review of the home's mobility aide cleaning schedule indicated that a resident s mobility aide had not been cleaned as scheduled at an identified date. Additionally, resident's mobility aide was noted to be visibly soiled during observations. During an interview with the Director of Care (DOC) and the Executive Director (ED), they

indicated that resident's mobility aides were to be cleaned weekly and on an as -needed -basis if any visible soil is present.

Sources: review of mobility aide cleaning schedule, observations and interviews with ED and DOC

WRITTEN NOTIFICATION: Maintenance Services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

A review of the water temperature logs for a certain period of time concluded that the logs were not completed for all units of the home. The review indicated that on several shifts during the specific time, water temperatures were not monitored. During an interview with the Environmental Services Manager (ESM), it was confirmed that water temperatures were to be monitored and recorded daily on each shift.

Sources: review of water temperature records and interview with ESM