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

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Public Report

Report Issue Date: January 13, 2026
Inspection Number: 2026-1234-0001
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 Aylmer, Aylmer

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7-9 and 12-13, 2026

The following intake(s) were inspected:

- Critical Incident (CI) 2740-000029-25 related to improper care for a resident:
- CI 2740-000030-25 related to improper care for a resident.

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

Resident Care and Support Services
Prevention of Abuse and Neglect

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 (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 resident was not provided with a treatment as set out in their plan of care. The clinical records indicated that the resident required the treatment to be implemented on a daily basis which was not applied for approximately three months.

Sources: Resident's electronic treatment administration record (eTAR); Home's Internal Investigation notes and interviews of staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 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 resident's plan of care directed staff to provide specific bathing care.

The resident had a task scheduled on Point of Care (POC) which required personal support staff to document on the bathing care they were provided. There was no documentation completed as scheduled on a specific date.

The provision of bathing care was not documented for the resident as set out in their plan of care.

Sources: CI #2740-000030-25; resident's clinical record, including their progress notes, care plan, and tasks; and staff interviews.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

A door to the Rose Meadow home area spa room was left open and a resident entered the spa room unsupervised.

The door to the Rose Meadow spa room was not kept closed and locked to restrict unsupervised access to this area by residents when unsupervised by staff.

Sources: CI #2740-000030-25; the home's investigation notes related to the incident, resident's clinical record, including their progress notes; and staff interviews.

WRITTEN NOTIFICATION: Maintenance services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

Procedures were not developed and implemented when a resident's medical equipment was not in a good repair or maintained.

Resident's clinical records indicated that on a specific date a registered staff member became aware that the resident's medical equipment was broken.

Executive Director (ED) acknowledged that registered staff should have assessed the medical equipment to ensure proper functioning. They confirmed that this was not completed for a three month period.

Sources: Review of resident's clinical records, a review of the home's investigative notes, the home's policy related to clinical procedures and care services, and interviews with registered staff and the ED.