

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: December 3, 2025

Inspection Number: 2025-1539-0007

Inspection Type:

Complaint
Critical Incident

Licensee: The Corporation of the City of London

Long Term Care Home and City: Dearness Home for Senior Citizens, London

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 27 and December 1- 3, 2025

The following intakes were inspected:

1. Intake #00161842 related to a complaint about resident care and medication management
2. Intake #00163217/Critical Incident System report #M514-000022-25 related to infection prevention and control

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

Medication Management
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Documentation in a resident's electronic medical records supports that in November, 2025, the home was aware of an issue regarding a resident and a co-resident. In interviews with the resident and staff, the resident recounted the issue regarding co-resident; staff #101 verified they were aware of a complaint from complainant and resident about the same issue and also recounted that they had emailed staff #102 about the concern; staff #102 and staff #103 verified they were aware of a written and verbal complaint from complainant; and staff #102 acknowledged the complaint had not been forwarded to the Director.

Sources: Record review of a resident's electronic medical record; interviews with staff #101, staff #102 and staff #103