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

London District
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London, ON, N6A 5R2
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Public Report

Report Issue Date: June 30, 2025
Inspection Number: 2025-1447-0006
Inspection Type: Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: McGarrell Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25-27, 30, 2025.

The following intake(s) were inspected:

- Intake: #00150032 - Critical Incident (CI) 2964-000015-25 related to injury causing change in condition.

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

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that

the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee failed to ensure that a resident's plan of care was revised when their care needs were no longer necessary.
In June, 2025, a resident's care plan indicated that the staff were to provide a specified intervention. The Director of Care (DOC) reported that the intervention was no longer necessary; however, the care plan had not been revised.
The care plan was subsequently revised to show that the care needs in relation to the use of the intervention had been resolved.

Sources
Interview with the DOC, a resident's care plan and observation of a resident.

Date Remedy Implemented: June 27, 2025

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.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented. A resident was assessed and their care plan indicated that the staff were to check every one hour throughout the night for safety. Interview with the Associate Director of Care (ADOC) and a Personal Support Worker (PSW) confirmed that the checks were not part of the Point of Care (POC) tasks and the provision of the care was not documented elsewhere.

Sources: Interview with the ADOC and PSW, review of a resident's plan of care.