

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: October 27, 2025

Inspection Number: 2025-1447-0008

Inspection Type:

Complaint
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): October 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 2025

The following intake(s) were inspected:

- Intake: #00154196, related to alleged resident to resident physical abuse.
- Intake: #00156837, related to alleged resident's neglect.
- Intake: #00157680, related to a resident's fall.
- Intake: #00158672, complaint related to resident care concerns.
- Intake: #00158698, related to a resident's fall.
- Intake: #00159251, related to disease outbreak.
- Intake: #00159250, related to disease outbreak.
- Intake: #00159622, related to improper/incompetent treatment or care of a resident.
- Intake: #00159894, related to allegations of resident's neglect.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to be treated with respect

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident's right to respect and dignity were fully respected and promoted during resident's care.

Sources: Resident's progress notes, Critical Incident System, and staff interviews.

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WRITTEN NOTIFICATION: Documentation

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 the documentation of provision of care for a resident as set out in their plan of care. There were no documentation that the resident's bath on two occasions were provided.

Sources: Resident's Clinical Record and staff interviews.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

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

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when there were reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident that it was immediately reported to the Director.

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There was a certain incident that involved a resident, the staff RN who witnessed the incident reported it to a manager the next day, however, the incident was reported to the Director immediately.

Sources: Critical Incident System, resident's clinical records, home's investigation notes, and staff interviews.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that a transfer equipment used for a resident's transfer and support was used in accordance with manufacturers' instructions. The manufacturer's safety Instructions warned that any resident using the equipment should not be left unattended at any time. The resident was left alone while using the equipment.

Sources: Resident observation and clinical records, Arjo Sara Flex Instructions For Use Manual, CIS, homes investigation notes, and staff interview.

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WRITTEN NOTIFICATION: Continence Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 3.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.

The licensee has failed to comply with the home's continence management program when a continence assessment was not conducted for a resident following a change in status.

In accordance with O. Reg 246/22, s. 11(1)(b), the licensee is required to ensure that written policies developed for the continence care and bowel management program were complied with.

Specifically, the home's CARE5-P10 Continence Care Program policy indicated a continence assessment was to be completed with any change in the resident's continence status that will include prevention and management of altered bladder and bowel function, evaluation of the type of incontinence, identifying contributing factors, and the consideration of the impact on resident's physical, emotional and social well-being.

Clinical record review and staff interview showed the resident had changes in their continence status but a continence assessment was not completed.

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Sources: resident's progress notes, Home's Continence Care program procedure and staff interview.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated;

The licensee failed to ensure that a resident was repositioned every two hours or more frequently as required due to their condition. The resident's plan of care required that the resident be turned and repositioned every two hours due to them being unable to do so on their own. The resident's record for a period of time indicated that the resident was being repositioned once per shift and not every two hours as required.

During interview with staff Personal Support Worker they said that the resident's repositioning was not in their Care Plan and that staff repositioned the resident only when the resident called for help and when the staff saw that the resident needed that. The Director Of Care and Assistant Director Of Care said the resident were to be repositioned every two hours to avoid impacting their skin integrity, and that it was in the resident's Care Plan.

Sources: Resident's Clinical Records, and staff Interviews.

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WRITTEN NOTIFICATION: Continence care and bowel management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (1) 4.

Continence care and bowel management

s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:

4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

The licensee failed to ensure the continence care and bowel management program for a resident provided strategies to maximize the residents' comfort and dignity when staff provided continence care for the resident in their equipment instead of in their bed, potentially causing discomfort, incomplete care, and harm to the resident due to their skin integrity.

The Ministry followed up on a complaint that staff were sometimes providing personal care for a resident in their equipment. A Personal Support Worker during interview confirmed that staff sometimes provided care for the resident in their equipment instead of their bed. The Director of Care (DOC) and Assistant Director of Care (ADOC) said staff should not provide continence care changes in a resident's equipment but in bed.

Sources: Complaint letter, and staff interviews.

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WRITTEN NOTIFICATION: Continence care and bowel management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee did not ensure that resident assessments for incontinence included identification of contributing factors, incontinence type and patterns, potential for improvement, and appropriate interventions. Additionally, when required, assessments were not completed using clinically appropriate tools designed for evaluating incontinence.

Specifically, a resident did not receive a comprehensive continence assessment following a care conference where a change in their continence status was identified. During the interview, the ADOC confirmed that the resident had not received a full continence assessment since before the change in status. The reassessment conducted recently focused solely on determining an appropriate incontinence product. The ADOC further stated that a full continence assessment should have been completed when changes in the resident's continence were identified.

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Sources: staff interviews, resident's clinical records and assessments, homes
continence care program policy.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee failed to ensure that the behavioural plan developed by the behavioural team for a resident was implemented.

The plan had required a specific intervention at scheduled times with specific instructions to ensure resident was not left unsupervised. However, the resident was left unattended for approximately 30 minutes during the scheduled time. During this time, the resident had an altercation with another resident.

Sources: Critical Incident Report, clinical records for two residents, behavioural assessments, and staff interviews.

WRITTEN NOTIFICATION: Medication Administration

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The home's Medication Administration policy and procedure was not fully implemented for a resident.

The home received a complaint concerns related to resident's medication administration.

The Home's Medication Management System procedure CARE13-010.01, LTC-Medication Administration, stated "Prescribed medications will be administered according to the scheduled medication administration times. Medication should be given within the recommended time frame, 60 minutes before and 60 minutes after the scheduled administration time."

A record review and staff interview showed medications being administered out of the 60 minutes window and confirmed the medication administration procedure was not implemented by the staff at all times.

Sources: complaint letter, home's medication administration policy, medication administration documentation report and staff interview.

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COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Retrain specific staff members on the home's IPAC Program related to proper PPE donning and doffing and the importance of adhering to enhanced IPAC precautions. Keep records of training dates, content materials used in training, and who provided the training.

2. Conduct at least two audits per each of the specific staff members over a period of three weeks on different shifts if applicable to ensure compliance with IPAC standards related to enhanced IPAC measures and routine IPAC practices. Keep documented records of these audits, including the date of completion, who audited, and any corrective actions taken.

3. The IPAC Lead should conduct a documented review of the effectiveness of the additional precautions implemented by staff in the outbreak home area of Windermere Way. Document any corrective actions taken.

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Grounds

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, issued by the Director, was implemented.

1. During an IPAC outbreak inspection, a Personal Support Worker was observed seated in resident's room without their mask providing one on one support when the home area was in outbreak with Rhinovirus and COVID-19.

According to the IPAC Standard, section 6.7, under additional requirement under the Standard, all staff shall always comply with applicable masking requirement at all times. Masking was in place at the time as the home area was in an outbreak.

2. During an IPAC outbreak inspection, a Personal Support Worker was observed seated across the table from a resident in the resident's room without wearing required eye protection feeding the resident. The resident was on both Droplet and Contact Precautions.

According to the IPAC Standard section 9.1, under additional requirement under the Standard, the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At a minimum, Additional Precautions shall include: (f) Additional PPE requirements including appropriate selection, application, removal and disposal. Eye protection was required for the resident's room.

3. During an IPAC outbreak inspection, two Activity Aids were observed exiting an outbreak unit wearing their N95 masks, they did not remove the contaminated masks and proceeded to common areas of the home that were not in an outbreak.

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According to the IPAC Standard section 9.1, under additional requirement under the Standard, the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At a minimum, Additional Precautions shall include: (f) Additional PPE requirements including appropriate selection application, removal and disposal. Removal of mask was required after exiting the outbreak home area to avoid spreading viruses as the home was in outbreak for both Rhinovirus and COVID-19 virus.

Sources: Observations of staff.

This order must be complied with by November 21, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
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Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.