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
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London, ON, N6A 5R2
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Public Report

Report Issue Date: April 30, 2026
Inspection Number: 2026-1447-0004
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): April 14, 15, 16, 20, 21, 22, 23, 24, 27, 28, 30, 2026

The following intake(s) were inspected:
- Intake: #00168946 - Critical Incident #2964-000002-26 related to an altercation between residents
- Intake: #00169391 - Critical Incident #2964-000004-26 related to a fall with injury
- Intake: #00170269 - Critical Incident #2964-000006-26 related to an altercation between residents
- Intake: #00171118 - A complaint alleging neglect of residents and other issues in the home.
- Intake: #00172531 - A complaint related to care
- Intake: #00173330 - Critical Incident #2964-000007-26 related to an injury of unknown cause.
- Intake: #00174710 - Critical Incident #2964-000009-26 related to a fall with injury
- Intake: #00175133 - A complaint related to falls prevention and management
- Intake: #00175741 - A complaint related to bathing care and privacy issues.
- Intake: #00176838 - A complaint related to resident safety and care concerns.

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

Resident Care and Support Services
Prevention of Abuse and Neglect

Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Based on assessment of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

A resident had a physical limitation for which they were receiving a treatment, but despite this, was worsening. There was no focus identifying the physical limitation, or direction in the plan of care related to associated pain, assistive devices, hygiene and grooming, or the risk of and prevention of infection and skin breakdown specific to that limitation.

Sources: Observations of and review of health records for a resident, and interviews with the resident's family, a Physiotherapy Assistant and an Assistant Director of Care.

WRITTEN NOTIFICATION: Weight changes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.
Weight changes

s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

A resident had a significant weight loss over the period of one month. There was no assessment completed by the Registered Dietitian (RD) until after a scheduled care conference was conducted over two weeks later.

Sources: Health records for a resident and interviews with the RD, an Assistant Director of Care and the Food Services Manager.