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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: April 10, 2026
Inspection Number: 2026-1448-0002
Inspection Type: Complaint Critical Incident
Licensee: The Women's Christian Association of London
Long Term Care Home and City: McCormick Home, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
April 7, 8, 9, and 10, 2026

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00166064 - CI #2965-000032-25 related to the Fall Prevention and Management Program
- Intake: #00172628 - CI #2965-000010-26 related to the Fall Prevention and Management Program
- Intake: #00173477 - CI #2965-000011-26 related to the Fall Prevention and Management Program
- Intake: #00174451 - CI #2965-000013-26 related to the Fall Prevention and Management Program
- Intake: #00174737 - CI #2965-000014-26 related to the Fall Prevention and Management Program

The following Complaint intake was inspected:

- Intake: #00175618 related to the Fall Prevention and Management Program

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

Medication Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The resident sustained an injury and their family member reported requesting a safety intervention, but there was no assessment for it's use and it was not in place when the resident required it. The Director of Care (DOC) verified the plan of care should have included the use of the intervention as a safety measure.

Sources: Resident record review the plan of care, assessments, progress notes, and Point of Care safety tasks, observations of the resident, and interviews with the registered staff, family member and Director of Care.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The Power of Attorney (POA) for the resident found two medications in the resident's room and a medication incident was completed with the dates of the missed doses unknown and no harm resulted.

Sources: Health records for the resident, medication incident report, and interview with the POA and DOC.