Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2021	2021_834524_0010	014588-21, 019045-21	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

McGarrell Place
355 McGarrell Drive London ON N6G 0B1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

INA REYNOLDS (524)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 9, 10 and 13, 2021.

The following Complaint Intakes were completed within this inspection:
Log # 014588-21 and Log # 019045-21 related to allegations of neglect of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Personal Support Workers, a Housekeeping Aide, Maintenance staff and residents.

The inspector(s) also conducted a tour of the home and observed resident care provisions and resident rooms, staff to resident interactions, and reviewed clinical healthcare records for identified residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

A complaint was received from resident #006 related to call bell response by staff. Resident #006 said that on a specific date, they used their call bell as they planned to get up. Resident #006 explained that they were unable to get out of bed on their own and required assistance from staff. Resident #006 said they waited patiently but no one responded to the call bell for a long time and that was their main concern. Resident #006 said they just wanted someone to come to check on them and let them know when a staff would be available to assist with their care needs. They were upset and crying, had screamed for help and could hear housekeeper #113 in the hall, but there was no reaction from them. The resident described the incident as a frightening experience and was concerned with their health.

A review of a call history report for the resident’s room on a specific date showed a call duration of over 1 hour.

PSW #110 and #115 both said it was an expectation in the home that staff respond to a call bell as soon as possible and if attending to other residents to complete a safety check. The Administrator agreed the call bell duration was extreme and said that staff were expected to acknowledge the resident’s request for help so they would not feel abandoned and to check for an emergency. There was increased risk to the resident related to their care needs not full respected and promoted.

Sources: Info-line complaint report; resident #006’s clinical records; the home's relevant reports; and, interviews with resident #006, the Administrator, PSW #110, PSW #115 and other staff. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #006's right to be properly cared for in a manner consistent with his or her needs is fully respected and promoted, to be implemented voluntarily.

Issued on this 23rd day of December, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.