

Ministry of Long-Term Care

Long-Term Care Operations Division Long-Term Care Inspections Branch London Service Area Office 130 Dufferin Ave, 4th Floor London ON N6A 5R2 Telephone: 1-800-663-3775 LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date Inspection Number	May 26, 2022 2022_1447_0001	
Inspection Type		
Critical Incident Syst	em 🛛 Complaint 🛛 Follow-Up	Director Order Follow-up
□ Proactive Inspection	SAO Initiated	Post-occupancy
Other		_
Licensee AXR Operating (National) LP, by its general partners Long-Term Care Home and City		
McGarrell Place, Londo	•	
Lead Inspector Rhonda Kukoly (213)		Inspector Digital Signature
Additional Inspector(s Cheryl McFadden (745)	;) , Loma Puckerin (705241)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9, 10, 11, 2022

The following intake(s) were inspected:

- Log #002327-22, complaint related to care, maintenance and infection prevention and control concerns
- Log #003972-22, critical incident #2964-000008-22, related to a medication incident
- Log #006382-22, critical incident # 2964-000014-22, related to falls

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.



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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 s.19 (2) (c)

The licensee has failed to ensure that bathroom doors in two of residents' rooms were maintained in a safe condition and were in a good state of repair.

On May 10, 2022, the bathroom doors in two residents' rooms did not have sliding tracks at the bottom of the door allowing them to swing outward when pulled. The home's maintenance staff installed the missing tracks and screws and scheduled an audit of the remaining doors in the home to ensure tracks were in place and in good repair.

There was no impact or risk to the residents as the tracks at the top of the doors were intact and due to the prompt repair of the bottom sliding tracks.

Date Remedy Implemented: May 11, 2022 [705241]