

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: March 9, 2026

Inspection Number: 2026-1543-0001

Inspection Type:

Critical Incident

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Elgin Manor, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 24, 25, 27, 2026 and March 2-5, 9, 2026

The following intake(s) were inspected:

- Intake: #00163639 / Critical Incident (CI) #M518-000044-25 related to an acute respiratory infection (ARI) outbreak.
- Intake: #00168182 / CI #M518-000003-26 related to falls prevention and management.
- Intake: #00170311 / CI #M518-000006-26 related to resident care and resident services.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident sustained an unwitnessed fall. At the time of the incident, the resident's care plan specified that they required a specific level of staff assistance, which was not provided.

Sources: Resident plan of care; interviews with staff.

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident's plan of care specified that they were to have specific equipment turned on at all times. However, on a specific date the equipment was not turned on, resulting in a period of distress for the resident.

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Sources: Resident plan of care; interviews with staff; critical incident report.

WRITTEN NOTIFICATION: Skin and wound care

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

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

Skin and wound care

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

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

A resident, who had sustained an injury and was identified as being at risk for altered skin integrity, did not receive a skin assessment of the affected areas. The home's registered staff identified that a skin assessment was not completed as required.

Sources: Skin Care and Wound Management Policy and Procedure; staff interviews; clinical health record for resident.