

**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**Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111Bureau régional de services de
Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111**Public Copy/Copie du rapport public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 8, 2021	2021_882760_0043	012295-21, 014645- 21, 018075-21, 018148-21	Critical Incident System

Licensee/Titulaire de permisAXR 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**Elginwood
182 Yorkland Street Richmond Hill ON L4S 2M9**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 2, 3, 6, 7, 2021.

The following intakes were completed in this critical incident inspection:

**A log was related to a fall;
Two logs were related to an allegation of staff to resident neglect;
A log was related to an allegation of staff to resident abuse.**

During the course of the inspection, the inspector(s) spoke with the Wound Care Champion (WCC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Infection Prevention and Control (IPAC) Manager, the Assistant Director of Care (ADOC) and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

**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. 2007, c. 8, s. 6 (7).**

Findings/Faits saillants :

1. The licensee failed to ensure that an agency PSW followed the resident's plan of care related to their transfer status.

An allegation of resident abuse was made, and the home initiated an investigation. The home's investigation indicated that an agency PSW was providing care to the resident on the date that the allegation occurred. The agency PSW stated they had used a transfer technique on the resident during their care that day. This transfer technique did not align with the resident's plan of care during that time. The ADOC confirmed that the agency PSW failed to follow the resident's transfer status from their plan of care. Failure to follow the resident's proper transfer status may result in harm to the resident.

Sources: Home's investigation of the incident; Review of the resident's plan of care; Interview with an ADOC and other staff. [s. 6. (7)]

Issued on this 8th day of December, 2021

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

Original report signed by the inspector.