Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 13, 2024	
Inspection Number: 2024-1354-0002	
Inspection Type: Critical Incident	
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.	
Long Term Care Home and City: Elginwood, Richmond Hill	
Lead Inspector Eric Tang (529)	**Inspector Digital Signature** Siu F Tang Digitally signed by Siu F Tang Date: 2024.06.18 07:33:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3 - 6, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:
An intake and a Critical Incident related to prevention of abuse and neglect.

An intake and a Critical Incident related to responsive behaviour.

An intake and a Critical Incident related to medication management.

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

Continence Care
Infection Prevention and Control

Medication Management
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 1.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
1. An emergency within the meaning of section 268, including fire, unplanned evacuation or intake of evacuees.

The licensee has failed to immediately inform the Director an emergency within the meaning of section 268 in as much detail as is possible in the circumstances.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director stating the resident had committed an action that would affect their health at the long-term care home (LTCH).

As per the resident's health records, the resident had committed an action during an evening but was quickly discovered by the staff. The resident was then transferred to a local medical facility for further assessment and treatment.

The Director of Care indicated that the incident was not reported to the Director until the next day and the matter should have been immediately reported to the Director as per the legislated requirement.

Sources: the resident's electronic health records, CI report, and staff interviews. [529]