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

London District
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Original Public Report

Report Issue Date: April 18, 2024	
Inspection Number: 2024-1055-0002	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare London, London	
Lead Inspector Tatiana McNeill (733564)	**Inspector Digital Signature** Tatiana McNeill Digitally signed by Tatiana McNeill Date: 2024.04.18 15:04:14 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 16, and 17, 2024

The following intake was inspected:

- Intake: #00107659 – Critical Incident System (CIS) related to allegations of prevention of abuse and neglect

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident's needs.

Rationale and Summary

A CIS report was submitted to the Director, related to an unwitnessed fall a resident sustained. According to the CIS report, the resident had an unwitnessed fall when they were left unattended. The CIS indicated that the resident had received external medical assessment, and returned to the home on the same day, with no acute findings.

Review of clinical records for the resident noted that prior to their fall, the resident had cognitive impairment, and had falls interventions in place.
In an interview, the Physiotherapist stated that the resident should have not been left unattended.

There was risk to the resident when they were left unattended.

Sources: review of CIS, review of clinical records for the resident, and interview with Physiotherapist. [733564]