

**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**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130, avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du rapport public**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 26, 2022	2022_932442_0001	015221-21	Critical Incident System

---

**Licensee/Titulaire de permis**

AXR 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**

Elmwood Place  
46 Elmwood Place West London ON N6J 1J2

---

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

STEPHANIE MORRISON (721442)

---

**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): January 17-20, 2022.**

**The following intake was completed in this Critical Incident System (CIS) inspection:**

**-Log #015221-21/CIS #2662-000010-21, related to a resident fall with a fracture.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a Housekeeper.**

**During the course of the inspection, the inspector(s) observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

**Inspector Debbie Warpula #577 was also present during this inspection.**

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

**Falls Prevention**

**Infection Prevention and Control**

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

**1 WN(s)**

**1 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 O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

A registered staff member had failed to perform hand hygiene prior to administering medications to two residents in a common area. The IPAC Lead stated that the expectation for hand hygiene during a medication pass was to have completed hand hygiene before and after administering medications to each resident. The IPAC Lead admitted that the actions of the registered staff member had not complied with this expectation.

A staff member had failed to perform hand hygiene between each resident while having served snack to multiple residents in a common area, and they had failed to offer assistance to residents to perform hand hygiene prior to having served them their snack. The IPAC Lead stated that the expectations while serving snacks was for the staff to have completed hand hygiene before each snack was prepared and after each snack was served, and for the staff to have assisted residents to complete hand hygiene prior to having served them their snack. The IPAC Lead admitted that the actions of the staff member had not complied with these expectations.

The two staff members having failed to participate in the implementation of the home's IPAC program, placed the residents at increased risk for contamination of infectious diseases.

Sources: observations of medication administration and snack service; the home's Hand Hygiene Procedure; Revera's COVID-19 Playbook; and interviews with staff. [s. 229. (4)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

**Issued on this 31st day of January, 2022**

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

**Original report signed by the inspector.**