Ontario

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

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 22, 2022
Inspection Number 2022_1168_0002
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Revera Long Term Care Inc.

Long-Term Care Home and City
Elmwood Place, London

Lead Inspector
Samantha Perry #740

Additional Inspector(s)
Christie Birch #740898

Inspector Digital Signature
Samantha Perry
Digitally signed by Samantha Perry
Date: 2022.08.23 08:27:36 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 10, 11, 15, 17, 18, 2022.

The following intake(s) were inspected:

- Intake # 011767-22 / CIS # 3054-000021-22 related to falls;
- Intake # 013361-22 / CIS # 3054-000025-22 related to falls;
- Intake # 007629-22 / CIS # 3054-000009-22 related to falls, and
- Intake # 010460-22 / CIS # 3054-000018-22 related to falls.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION DOORS IN A HOME

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 12(1)3.*

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The licensee has failed to ensure that all doors residents should not have access to were kept closed and locked.

Rationale and Summary

During the course of Infection Prevention and Control (IPAC) observations, it was observed that the tub/shower room door was open, the clean utility room door was unlocked, and the clean and soiled linen cart room doors were open in the Victoria Park resident care area. The clean utility and communication closet room doors were unlocked in the Springbank resident care area. The communication closet room, equipment room, and soiled linen cart room doors were all open in the Gibbons Park resident care area, and the communication closet room door was unlocked in the East Park resident care area.

Interviews with Administrator #100, Director of Care (DOC) #101, Personal Support Worker (PSW) #103, PSW #104 and PSW #110 all said the tub/shower room doors, clean utility room doors, communication closet doors, the equipment room doors, and the soiled and clean linen cart room doors all should have been closed and locked.

The risk was increased when the doors to the clean utility room, tub/shower room, equipment room, communication closet room, and the clean and soiled linen rooms were left open or unlocked, allowing unsupervised access to those areas by residents.

Sources: Observations and interviews with staff and management.

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