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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: November 19, 2024

Inspection Number: 2024-1168-0004

Inspection Type:
Complaint
Critical Incident
Follow-up

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: Elmwood Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 28, 29, 31, 2024 and November 1, 4, and 5, 2024
The inspection occurred offsite on the following date: October 30, 2024
The following intakes were inspected:

- Intake: #00124211 - Complainant regarding Resident Care and Services.
- Intake: #00124219 – CIS# 3054-000028-24 – related to a COVID-19 Outbreak Management.
- Intake: #00124492 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (10) (b)
- Intake: #00129244 – CIS# 3054-000035-24 – related to a COVID -19 Outbreak Management.
- Intake: #00129482 – CIS# 3054-000036-24 -related to Falls Prevention and Management.
- Intake: #00130175 - Complainant related to Resident Care and Services.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1168-0003 related to FLTCA, 2021, s. 6 (10) (b).

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that care set out in the plan of care was provided to the resident as outlined in the plan.

Summary and Rationale:
The Ministry of Long-Term Care received a complaint related to concerns that a resident's care plan was not being followed as outlined. Part of the complaint

indicated that the resident sustained a fall as a result of the care plan not being followed.

PSW acknowledged that the resident's care plan was not followed.

There was risk to the resident when their care plan was not followed.

Sources: Interview with staff, progress notes, and resident's care plan and Kardex.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 care set out in the resident's plan of care was based on the needs and preferences of the resident.

Summary and Rationale:
The Ministry of Long-Term Care received a complaint related to concerns about a resident's plan of care that did not include interventions related to their care needs.

Staff member acknowledged that resident's plan of care did not include interventions related to the resident's care needs.

There was risk to the resident when their plan of care did not include interventions related to their care needs.

Sources: Interview with staff, observation of resident 's room, resident's care plan.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to administer medication to a resident in accordance with directions specified by prescriber.

Summary and Rationale:
The Ministry of Long-Term Care received a complaint. Part of the complaint cited concerns over a medication incident that took place with a resident.

Administrator acknowledged that the resident's medications were not given to them as a result of this incident.

There was risk to the resident when they did not receive their medications as prescribed.

Sources: Interviews with Administrator and staff, medication incident report.