

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

Public Report

Report Issue Date: February 13, 2025

Inspection Number: 2025-1168-0002

Inspection Type:

Proactive Compliance Inspection

Licensee: Axiom Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axiom Extendicare LTC II GP Inc.

Long Term Care Home and City: Elmwood Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7, 10, 11, 12, 13, 2025

The following intake(s) were inspected:

- Intake: #00138368 - Proactive Compliance Inspection - 2025

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

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Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of care set out in the plan of care for a resident was documented.

There were concerns about a resident's skin integrity. The care plan required repositioning every two hours, but there was no documentation of this repositioning.

The Director of Care (DOC) stated that in November 2024, corporate requested the home to streamline tasks in Point of Care (POC), leading to the removal of the repositioning task from documentation. The task was reactivated upon the inspector's request. There were no previous records of repositioning, making it unclear if the staff had been performing the task.

Sources: Resident clinical record review and interviews with the resident's family member and Director of Care (DOC).

WRITTEN NOTIFICATION: Doors in a home

NC #002 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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Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure doors to non-residential areas were kept closed and locked when not supervised by staff.

During the Proactive Compliance Inspection (PCI), the inspector found several unsecured doors leading to non-residential areas. These non-compliances were reported to the Executive Director (ED), who agreed to ensure doors were always locked.

Follow-up observations revealed further unsecured doors leading to non-residential areas in the home.

The presence of unsecured doors in frequently used residential areas poses a potential risk to resident safety.

Sources: Observation

Doors to the tub room in a home area were found open with no staff and no resident present. There was cleaning disinfectant accessible in the room, posing a risk to residents' health and safety. The inspector witnessed a resident walk by the bathroom unsupervised.

The Executive Director said the doors should have been closed.

Sources: Observation and Executive Director interview.

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WRITTEN NOTIFICATION: Hazardous substances

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 97

Hazardous substances

s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Doors to a tub room were found open with no staff and no resident present. There was a cleaning disinfectant labeled as poisonous and corrosive that was accessible in the room, posing a risk to residents' health and safety. The inspector witnessed a resident walk by the bathroom unsupervised.

Sources: Observation.