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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London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: June 9, 2025

Inspection Number: 2025-1168-0004

Inspection Type:
Complaint
Critical Incident

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 date(s): May 22, 23, 26, 27, 28, 29, 30, 2025 and June 2, 3, 4, 5, 6, 9, 2025

The following intake(s) were inspected:

- Intake #00144665 / 3054-000018-25 related to a resident to resident altercation
- Intake #00145410 / 3054-000021-25 and #00146801 / 3054-000023-25 related to fall prevention and management
- Intake #00145837, #00146442 and #00148083 related to resident care concerns

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

Resident Care and Support Services
Continence Care
Medication Management
Prevention of Abuse and Neglect

Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Laundry Service

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items;

The licensee has failed to ensure that the process to report and locate a resident's personal item was implemented.

The resident's records identified that a registered staff member was notified that the personal item was missing. The Director of Care confirmed that they were not made aware of the missing personal item and the home had not implemented procedures to report and locate the item.

Sources: A review of the resident's records; the home's complaints binder and procedures; and interviews.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee has failed to ensure the home monitored and documented a resident's response after receiving a psychotropic medication.

The resident had an order for an antipsychotic medication and on specific dates, there were changes made to the medication order. During a review of the resident's medical records, no antipsychotic medication monitoring tools were completed with the initiation of and subsequent changes to the medication order.

On a specific date, a new order was received for the resident's antipsychotic medication and an antipsychotic medication monitoring tool was initiated, however, inconsistently completed. Subsequently, when the medication was discontinued, a new monitoring tool was not initiated.

Sources: The resident's clinical records; the home's Psychotropic Medication Procedure; and interviews with staff and management.