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

Public Report

Report Issue Date: September 18, 2025
Inspection Number: 2025-1168-0007
Inspection Type: 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): September 12, 15, 16, 17, 18, 2025

The following intake(s) were inspected:
-Intake: #00154515 -Critical Incident System Report- 3054-000044-25 related to a fall.
-Intake: #00156264 -Critical Incident System Report-3054-000048-25 related to a fall.
-Intake: #00157450 -Critical Incident System Report- 3054-000034-25 related to an injury of unknown origin.

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Falls Prevention and 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 for a resident was documented.

A Personal Support Worker (PSW) documented on the home's Point of Care (POC) system that a resident was provided with care when they were not.

Sources: Critical Incident (CI) report; the resident's clinical record, including their care plan and tasks; the home's investigation notes; and staff interviews.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with when a resident's Power of Attorney (POA) was not immediately notified related to an alleged incident of resident abuse.

The home's immediate response and reporting of abuse or neglect procedure which was part of their zero tolerance of abuse and neglect program policy directed incident managers to disclose alleged abuse to a resident's POA immediately upon becoming aware of an incident of alleged abuse.

The resident's POA was not made aware that the home was conducting an investigation related to a suspected incident of abuse until the investigation had concluded.

Sources: A Critical Incident (CI) report; the home's policy "CARE19-P20.01-Immediate Response and Reporting of Abuse or Neglect Procedure"; and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for

skin and wound assessment,

The licensee failed to ensure that a resident received a skin assessment, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A resident sustained an injury that required treatment. A skin and wound assessment was not completed for the area of altered skin integrity and should have been.

Sources: Resident's clinical records, including progress notes and assessments; and interviews staff.

WRITTEN NOTIFICATION: Therapy services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 65 (a)
Therapy services
s. 65. Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 13 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and

The licensee failed to ensure that physiotherapy services for a resident were arranged based on their individualized needs.

A resident sustained a fall and a physiotherapy referral was initiated by the registered nursing staff for the resident to be assessed by the Physiotherapist. The

resident was not assessed until multiple referrals had been made over an extended period of time, due to an error within the referral system, which resulted in the physiotherapist (PT) not being notified about the referrals. The PT additionally did not receive any communication from staff that the resident required assessment.

Sources: The home's Specialized Rehabilitation policy (number CARE15-P10.03); the home's facility bulletin board; the resident's clinical records, including progress notes, and assessments; and interviews with the PT and other staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee failed to ensure a Critical Incident Report (CIS) was amended to include the outcome or current status of the resident involved in the incident.

Sources: CIS report; resident's clinical records, including their census information; and interviews with staff.