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: October 25, 2023	
Inspection Number: 2023-1447-0006	
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: McGarrell Place, London	
Lead Inspector Leah Carrier (000748)	**Inspector Digital Signature** Leah N Carrier Digitally signed by Leah N Carrier Date: 2023.10.25 16:18:51 -04'00'
Additional Inspector(s) N/A	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23 & 24, 2023

The following intake was inspected:

- Intake #00096064 [CI #2964-000034-23]: Fall of resident resulting in significant change in health status

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

In accordance with FLTCA, 2021 s. 6 (1) (c), the licensee was required to ensure that the written plan of care for the resident set out clear directions to staff and others who provide direct care to the resident.

A resident, who was identified as high-risk for falls, fell, resulting in a significant change in their health status. The resident's care plan contained interventions to mitigate their risk of falling. A review of the resident's progress notes identified that an additional falls intervention was ordered and implemented for the resident. In interviews with staff, they reported that the specified intervention was actively in place for the resident to mitigate their risk of falls. In a review of the resident's care plan, the specified intervention was not documented as a fall prevention intervention for the resident.

Management acknowledged that the specified intervention was not documented in the resident's care plan. Management added the specified intervention to the resident's care plan. A review of the resident's updated care plan confirmed that the specified intervention was added related to falls prevention and management.

Sources: resident record review; staff interviews
[000748]

Date Remedy Implemented: October 24, 2023