

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: December 20, 2024

Inspection Number: 2024-1447-0006

Inspection Type:

Complaint

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 13, 16, 18-20, 2024.

The following complaint intake was inspected:

- Intake: #00132469 - regarding neglect of a resident

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

- Contenance Care
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Falls Prevention and Management
- Restraints/Personal Assistance Services Devices (PASD) Management

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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)

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 the care set out in a resident's plan of care was based on an assessment of the resident's care needs. A staff member assessed a resident as requiring a device for positioning and comfort, but the resident's plan of care did not include the use of the device.

On December 18, 2024, the resident's plan of care was updated to include the assessed need for the device.

Sources: observations of the resident, review of the resident's progress notes and plan of care, and an interview with the Associate Director of Care.

Date Remedy Implemented: December 18, 2024

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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 had failed to ensure the care set out in a resident's plan of care was based on an assessment of the resident. The resident was assessed to require a particular intervention for falls prevention. This intervention was not implemented into the resident's plan of care prior to their fall with significant change, when they did not have the assessed falls intervention in place.

Sources: review of the resident's plan of care, progress notes, and assessments, and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director, was complied with.

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In accordance with Routine Practices 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure a staff member completed hand hygiene after contact with multiple residents.

Sources: observations of hand hygiene, and an interview with a staff member.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

The licensee has failed to ensure all staff participated in the implementation of the home's IPAC program when a resident's medical device was observed to be improperly stored in a way that was an IPAC concern for the resident. The IPAC Lead stated the medical device was to be stored in a specific way for best practice.

Sources: observations of the resident's medical device storage, and interviews with the IPAC Lead and the DOC.