

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central East District**

33 King Street West, 4th Floor  
Oshawa, ON, L1H 1A1  
Telephone: (844) 231-5702

## Original Public Report

**Report Issue Date:** September 10, 2024

**Inspection Number:** 2024-1354-0003

**Inspection Type:**

Critical Incident

**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:** Elginwood, Richmond Hill

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26-30, and September 3-5, 2024.

The following intake(s) were inspected in the Critical Incident (CI) inspection:

- Two intakes were related to injuries of unknown cause.
- Two intakes were related to Falls prevention and management.
- One intake was related to an outbreak of disease of Public Health significance.

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

Resident Care and Support Services  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Falls Prevention and Management

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central East District**

33 King Street West, 4th Floor  
Oshawa, ON, L1H 1A1  
Telephone: (844) 231-5702

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Falls prevention and management

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

**Non-compliance with: O. Reg. 246/22, s. 54 (1)**

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that a resident was properly monitored and provided with their assistive aid as outlined in their fall prevention and management strategies.

#### Rationale and Summary

The Long-Term Care Home (LTCH) submitted a Critical Incident Report (CIR) indicating the resident had experienced an incident and was sent to a local medical facility for treatment. The resident's plan of care required staff to remind the resident to use a specific assistive aid for safe movement around the unit. Additionally, the resident's care plan specified the need for supervision and setup assistance to move safely within the LTCH.

A Personal Support Worker (PSW) was aware the resident utilized the assistive aid. On a specified day, the PSW encouraged the resident to move from one area to another on the unit without their assistive aid. The PSW confirmed they left the area

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central East District**

33 King Street West, 4th Floor  
Oshawa, ON, L1H 1A1  
Telephone: (844) 231-5702

to retrieve another assistive aid because the resident's assistive aid was not available. Upon returning, they found the resident had an incident and sustained an injury that required transfer to a local medical facility for treatment.

The Assistant Director of Care (ADOC) confirmed that the PSW failed to provide the necessary assistive aid and supervision.

The resident experienced an incident with injury after the PSW encouraged them to move without their assistive aid and left them unsupervised.

**Sources:** The resident's clinical record, CIR, interviews with the PSW and ADOC.