



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des Soins  
de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection prévue  
sous la Loi de 2007 sur les foyers  
de soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 17, 2019	2019_736689_0002	013406-18, 029781-18	Critical Incident System

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**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.  
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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**Long-Term Care Home/Foyer de soins de longue durée**

Extendicare London  
860 Waterloo Street LONDON ON N6A 3W6

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

CASSANDRA ALEKSIC (689), INA REYNOLDS (524)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): January 15 and 16, 2019.**

**The following intakes were completed in this Critical Incident System Inspection:**

**Critical Incident Log #013406-18 / CI 2173-000015-18 related to resident to resident abuse, and**

**Critical Incident Log #029781-18 / CI 2173-000029-18 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Coordinator, the Behavioural Supports Ontario Registered Nurse, Registered Practical Nurses, one Personal Support Worker and several residents.**

**The inspectors also observed residents, reviewed health care records and plans of care for the identified residents.**

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

**Falls Prevention**

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**

**2. A description of the individuals involved in the incident, including,**

- i. names of all residents involved in the incident,**
- ii. names of any staff members or other persons who were present at or discovered the incident, and**
- iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the report to the Director included the names of all residents involved in the incident.

A Critical Incident System (CIS) Report documented the initials of resident #003, who was involved in an incident of physical abuse towards resident #001.

Review of resident #003's progress notes in Point Click Care (PCC) identified that the resident's name matched the initials recorded as part of the CIS report.

On January 16, 2019, Director of Care #107 verified that resident #003's name was not documented as part of the CIS report as one of the residents who was present at the time of the incident, and acknowledged that the resident's name should have been recorded and not just their initials.

The licensee has failed to ensure that the report to the Director included the name of resident #003 who was involved in the incident. [s. 104. (1) 2.]

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**Issued on this 17th day of January, 2019**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**