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 30, 2023

Inspection Number: 2023-1168-0005

Inspection Type:
Complaint
Critical Incident
Follow up

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

Lead Inspector	**Inspector Digital Signature**
Tatiana Pyper (733564)	Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2023.11.07 16:09:32 -05'00'

Additional Inspector(s)
Julie Lampman (522)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 20, 23, 24, and 25, 2023
The inspection occurred offsite on the following date(s): October 23, 2023

The following intake(s) were inspected:
- Intake: #00096020 - Complaint related to care and services
- Intake: #00096370 - Follow-up #: 1 Compliance Order #001-FLTCA, 2021 - s. 24 (1)
- Intake: #00096371 - Follow-up #: 2 Compliance Order #002 -O. Reg. 246/22 - s. 53 (1) 1.
- Intake: #00098524 - CIS #3054-000033-23: related to Falls Prevention and Management.

The following intakes were also inspected:
- Intake: #00099074 - CIS# 3054-000034-23: related to Falls Prevention and Management.
- Intake: #00094664 - CIS #3054-000025-23 related to Falls Prevention and Management.
- Intake: #00095379 - CIS #3054-000026-23: related to Falls Prevention and Management.
- Intake: #00095954 - CIS #3054-000029-23: related to Falls Prevention and Management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1168-0004 related to FLTCA, 2021, s. 24 (1) inspected by Tatiana Pyper (733564)

Order #002 from Inspection #2023-1168-0004 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Julie Lampman (522)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the care of the resident so that their assessments were integrated, and were consistent with, and complemented each other.

Rationale and Summary
After an incident, a resident sustained a significant change in their health. A Registered Practical Nurse (RPN) completed a lift and transfer assessment of the resident. The assessment stated a consultation with the rehab team was not required.

The RPN stated that they had completed the lift and transfer assessment for the resident without seeing the resident, as a part of the required quarterly assessments.

The Director of Care stated the resident's lift and transfer assessments should have been completed to reflect the resident's current condition.

There was no impact to the resident.

Sources:
Review of resident's clinical records and interviews with RPN and the DOC.

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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 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
The resident sustained a significant change in their health and needed to seek medical attention.

The Registered Nurse (RN) provided information related to resident's plan of care that was not current and up to date.

The RN stated that they did not see the up-to-date information in the resident's chart and acknowledged that they did not provide the most up-to-date information when the resident was required to seek medical attention.

The Director of Care (DOC) stated that when resident's information was updated, staff did not remove old information from residents' charts, and the home was currently conducting audits to update residents' records.

There was low risk to the resident when the care set out in a resident's plan of care related was not provided to the resident as specified in the plan.

Sources:
Review of resident's clinical records, the home's policy reviewed March 31, 2023, and interviews with RNs, Physician, and the DOC.

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WRITTEN NOTIFICATION: Reports Re: Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.

The licensee has failed to ensure that the report to the Director related to an incident that caused an injury to a resident for which the resident sustained a significant change in the resident's health condition, included the names of the of staff present during the resident's injury.

Rationale and Summary
A Critical Incident System (CIS) report was submitted to the Director related to an incident that caused a significant change in their health, and did not include the name of the staff member who was present during resident's injury.

The Director of Care (DOC) stated they did not know the names of the staff members at the time they submitted the CIS report and they had not updated the CIS report with the names of the staff who was present during resident's injury.

There was no risk to the resident by not including the staff name on the report to the Director.

Sources:
Review of CIS report, and interviews with the DOC and other staff.

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