



Ministry of Long-Term Care Long-Term Care Operations Division Long-Term Care Inspections Branch London Service Area Office 130 Dufferin Ave, 4th Floor London ON N6A 5R2 Telephone: 1-800-663-3775 LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date Inspection Number	August 22, 2022 2022_1168_0002		
Inspection Type ☑ Critical Incident Syst ☐ Proactive Inspection ☐ Other	•	□ Follow-Up	☐ Director Order Follow-up☐ Post-occupancy
Licensee Revera Long Term Care	e Inc.		
Long-Term Care Home Elmwood Place, London	•		
Lead Inspector Samantha Perry #740			Inspector Digital Signature
Additional Inspector(s Christie Birch #740898			

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 10, 11, 15, 17, 18, 2022.

The following intake(s) were inspected:

- Intake # 011767-22 / CIS # 3054-000021-22 related to falls;
- Intake # 013361-22 / CIS # 3054-000025-22 related to falls;
- Intake # 007629-22 / CIS # 3054-000009-22 related to falls, and
- Intake # 010460-22 / CIS # 3054-000018-22 related to falls.

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

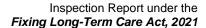
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION DOORS IN A HOME

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

|--|





Ministry of Long-Term Care Long-Term Care Operations Division Long-Term Care Inspections Branch London Service Area Office 130 Dufferin Ave, 4th Floor London ON N6A 5R2 Telephone: 1-800-663-3775 LondonSAO.moh@ontario.ca

The licensee has failed to ensure that all doors residents should not have access to were kept closed and locked.

Rationale and Summary

During the course of Infection Prevention and Control (IPAC) observations, it was observed that the tub/shower room door was open, the clean utility room door was unlocked, and the clean and soiled linen cart room doors were open in the Victoria Park resident care area. The clean utility and communication closet room doors were unlocked in the Springbank resident care area. The communication closet room, equipment room, and soiled linen cart room doors were all open in the Gibbons Park resident care area, and the communication closet room door was unlocked in the East Park resident care area.

Interviews with Administrator #100, Director of Care (DOC) #101, Personal Support Worker (PSW) #103, PSW #104 and PSW #110 all said the tub/shower room doors, clean utility room doors, communication closet doors, the equipment room doors, and the soiled and clean linen cart room doors all should have been closed and locked.

The risk was increased when the doors to the clean utility room, tub/shower room, equipment room, communication closet room, and the clean and soiled linen rooms were left open or unlocked, allowing unsupervised access to those areas by residents.

Sources: Observations and interviews with staff and management.

740