Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 11, 2021	2021_715672_0026	001524-21, 005833-21, 008672-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Fenelon Court
44 Wychwood Crescent Fenelon Falls ON K0M 1N0

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 7, 8, 9, 13, 14 and 15, 2021

The following intakes were completed during this inspection:

Two intakes related to resident falls with injuries which the residents were transferred to hospital for and resulted in significant changes in conditions.

One intake related to an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Recreation Manager (RM), Nutritional Manager (NM), Physiotherapist, IPAC Lead, MDS/RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), housekeepers, recreation aides, health screeners, maintenance workers, essential caregivers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Nutritional Care, Resident Abuse and Neglect, Fall Preventions, Safe Handling, Resident Transfers and Hot Weather. The Inspector(s) also observed staff to resident and resident to resident care and interactions, along with infection control and medication administration practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #013 received care as was specified in their plan of care.

A Critical Incident Report was submitted to the Director related to a fall sustained by resident #013 which resulted in the resident being transferred to hospital and diagnosed with an injury. Resident #013 was transferred back to the home and fall prevention interventions were implemented.

Inspector observed resident #013 did not have some of the identified fall prevention interventions implemented. During separate interviews, PSWs #104 and #116 indicated resident #013 was required to have the fall prevention interventions implemented. The DOC indicated it was an expectation in the home for residents to receive care as was specified in their plan and verified resident #013 had not received the interventions identified within their written plan of care.

By not ensuring resident #013 received care as was specified in their plan, they were placed at increased risk of sustaining further falls and/or injuries as a result of falling.

Sources: Observations conducted, resident #013's written plan of care, interviews with PSWs #104, #116 and the DOC. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents receive care as specified in their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy which promoted zero tolerance of abuse and neglect of residents was complied with related to an allegation of staff to resident abuse.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse which occurred the previous day. The CIR indicated that recreation staff #117 informed the Recreation Manager they had observed an alleged incident of staff to resident abuse the day prior.

Record review of the internal policy related to resident non-abuse indicated that anyone who became aware of or suspected abuse or neglect of a resident must immediately report that information.

Review of the internal investigation notes and resident #015's progress notes indicated the allegation of staff to resident abuse was not reported until one day after the alleged incident occurred.

During an interview, the Administrator verified the allegation of staff to resident abuse had not been immediately reported by recreation staff #117.

By not ensuring the written policy that promoted zero tolerance of abuse and neglect of residents was complied with when an allegation of staff to resident abuse was not immediately reported by a staff member, residents were placed at risk of possibly being exposed to further incidents of staff to resident abuse and/or neglect.

Sources: Internal policy related to resident non-abuse; Critical Incident Report; resident #015's progress notes; the internal investigation notes and interviews with the DOC, Administrator and the Recreation Manager. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy which promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques including safe positioning, were used to assist residents #008, #009 and #010, who required assistance with eating.

Residents #008, #009 and #010 were served their meals and received assistance from staff with their intake while seated in unsafe positions.

During separate interviews, PSW #111, the DOC and the Administrator indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake, to minimize the risk of residents choking and/or aspirating.

By not ensuring residents were in safe positions during food and fluid intake, residents were placed at risk of experiencing episodes of choking and/or aspiration.

Sources: Observations conducted, resident #008, #009 and #010's plans of care and interviews with PSWs, RPNs, RNs, DOC and the Administrator. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that proper techniques including safe positioning are used to assist residents who require assistance with eating, to be implemented voluntarily.

Issued on this 12th day of August, 2021

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

Original report signed by the inspector.