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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OSHAWA ON L1H 1A1
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, 2021	2021_673672_0035	012630-21, 012797-21, 012798-21, 013025-21, 013409-21	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): October 12, 13, 14, 15, 18, 19 and 20, 2021

The following intakes were completed during this Follow up and Critical Incident System inspection:

One intake related to following up on the outstanding Compliance Order #002, issued in inspection #2021_715672_0027, regarding s. 36 of O.Reg 79/10 of the LTCHA, with a Compliance Due Date of September 1, 2021.

One intake related to following up on the outstanding Compliance Order #001, issued in inspection #2021_715672_0027, regarding s. 229 (4) of O.Reg 79/10 of the LTCHA, with a Compliance Due Date of September 1, 2021.

Three intakes related to allegations of staff to resident abuse and/or neglect.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Director of Care, RAI Coordinator, IPAC Lead, Regional Manager, Regional Director for Clinical, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Aides (RA), Housekeepers, Environmental Services Workers (ESW), screeners, essential visitors and residents.

The inspector(s) reviewed clinical health records of identified residents and internal policies related to Fall Prevention and Head Injury Review, Hot Weather management, Prevention of Resident Abuse and Neglect, Medication Administration and Infection Prevention and Control. The Inspector(s) also observed staff to resident and resident to resident care and interactions, medication administration and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2021_715672_0027	672
O.Reg 79/10 s. 36.	CO #002	2021_715672_0027	672

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 residents #004 and #005 received care as was specified in their plan, related to continence care.

A Critical Incident Report was submitted to the Director regarding an allegation of staff to resident neglect, involving PSWs #108, #109 and residents #004 and #005. The CIR indicated the licensee received a written complaint from resident #004's family member, which alleged that residents #004 and #005 were found in unkempt states.

Record review indicated residents #004 and #005 were to receive identified interventions and specified care. Review of the internal investigation notes indicated that PSWs #108 and #109 did not provide care to the residents as was specified in their plans.

PSWs #108 and #109 were no longer employed in the home, therefore could not be followed up with related to the alleged incident. During separate interviews, the Acting Administrator and Regional Manager indicated the expectation in the home was for care to be provided to all residents as was specified in their plan. It was further verified that PSWs #108 and #109 had not provided care to residents #004 and #005, as was specified in their plans.

Sources: Resident #004 and #005's written plans of care; interviews with the Acting Administrator and the Regional Manager. [s. 6. (7)]

2. The licensee has failed to ensure residents #002, #006 and #007 received care as was specified in their plans.

Two Critical Incident Reports were submitted to the Director regarding allegations of staff to resident abuse and neglect, involving PSWs #103, #104, #105 and residents #002, #006 and #007. The first CIR indicated PSW #105 alleged PSW #103 did not provide care as required. The second CIR indicated PSW #104 alleged PSW #103 abused residents while providing care, including resident #002.

Review of the internal investigation notes indicated PSW #103 reported an identified number of staff would provide personal care to resident #002. Review of resident #002's written plan of care and MDS Assessment indicated the resident required a different level of care provided by a different number of staff members. The internal investigation notes further indicated PSW #103 reported residents would receive an identified intervention. Review of the internal Continence Care Program and during separate interviews, the Acting Administrator and Regional Manager indicated the expectation in the home was for residents to receive a different identified intervention. The Acting Administrator and Regional Manager further indicated the expectation in the home was for care to be

provided to all residents as was specified in their plan. PSWs #103 and #104 were no longer employed in the home, therefore could not be followed up with related to the alleged incidents.

Sources: Resident #002's written plan of care, MDS Assessment and other identified documentation; internal policy related to continence care; internal Revera Continence Care Program and interviews with PSW #105, the Acting Administrator and Regional Manager. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' SDMs were notified of the results of the alleged abuse or neglect investigations immediately upon the completion.

Three Critical Incident Reports were submitted to the Director regarding allegations of staff to resident abuse and neglect, involving PSWs #103, #104, #105, #108, #109 and residents #002, #004, #005, #006 and #007. The first CIR indicated PSW #105 alleged PSW #103 did not provide care as required. The second CIR indicated PSW #104 alleged PSW #103 used force while providing care, including to resident #002. The third CIR indicated the licensee received a written complaint from resident #004's family member, which alleged that residents #004 and #005 were found in unkempt states.

Inspector reviewed the three CIRs related to allegations of staff to resident abuse and neglect, progress notes for residents #002, #004, #005, #006 and #007 from the date of the alleged incidents to ten days following the completion of each of the internal investigations, internal investigation notes for each of the completed internal investigations and the internal Risk Management reports which were available related to the alleged incidents. There was no documentation which indicated that the residents' SDMs were notified of the results of the alleged abuse or neglect investigations immediately upon the completion.

During separate interviews, the Acting Administrator and Regional Manager indicated the expectation in the home was for the SDMs to be notified of the results of every alleged abuse or neglect investigation immediately upon completion and the notification was to be documented within the internal investigation notes. The Acting Administrator and Regional Manager further indicated they were unsure if the SDMs had been notified of the outcome of each of the internal investigations, due to not working in the home at the time of the alleged incidents and not having any documentation which indicated the notifications had occurred. The Administrator and Director of Care working in the home at the time of the incidents were no longer employed in the home, therefore could not be followed up with related to the alleged incidents.

Sources: The three CIRs; progress notes for residents #002, #004, #005, #006 and #007 from the date of the alleged incidents to ten days following the completion of each of the internal investigations; internal investigation notes for each of the completed internal investigations; Risk Management reports available related to the alleged incidents; interviews with the Acting Administrator and Regional Manager. [s. 97. (2)]

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 resident SDMs are notified of the results of every alleged abuse or neglect investigation immediately upon completion, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was used exclusively for drugs and drug-related supplies and was kept secured and locked.

During observations conducted in the home, Inspector noted that several bottles of medicated treatment creams were stored in resident #001's bedroom.

During separate interviews, RPN #106 and the Regional Manager indicated the expectation in the home was for medicated treatment creams to be stored in the locked medication room when not being used.

By not ensuring that drugs were stored in an area or medication cart that was kept secured and locked when not in use, residents were placed at risk of ingesting and/or incorrectly applying medicated treatment creams without the knowledge or supervision of staff.

Sources: Observations conducted, interviews with RPN #106 and the Regional Manager. [s. 129. (1) (a)]

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 drugs are stored in an area or medication cart that is used exclusively for drugs and drug-related supplies and is kept secured and locked when not in use, to be implemented voluntarily.

Issued on this 4th day of November, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JENNIFER BATTEN (672)
Inspection No. / No de l’inspection :	2021_673672_0035
Log No. / No de registre :	012630-21, 012797-21, 012798-21, 013025-21, 013409-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 3, 2021
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
LTC Home / Foyer de SLD :	Fenelon Court 44 Wychwood Crescent, Fenelon Falls, ON, K0M-1N0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Wayne Connelly

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To AXR Operating (National) LP, by its general partners, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

1) Prepare and implement a plan to determine how the home will ensure residents receive care as specified in their plan, specific to continence care, repositioning and mobility.

Please submit the plan to CentralEastSAO.MOH@ontario.ca, Attention: Jennifer Batten, Inspector #672 by November 8, 2021.

Grounds / Motifs :

1. The licensee has failed to ensure residents #004 and #005 received care as was specified in their plan, related to continence care.

A Critical Incident Report was submitted to the Director regarding an allegation of staff to resident neglect, involving PSWs #108, #109 and residents #004 and #005. The CIR indicated the licensee received a written complaint from resident #004's family member, which alleged that residents #004 and #005 were found in unkempt states.

Record review indicated residents #004 and #005 were to receive identified interventions and specified care. Review of the internal investigation notes indicated that PSWs #108 and #109 did not provide care to the residents as was specified in their plans.

PSWs #108 and #109 were no longer employed in the home, therefore could not

be followed up with related to the alleged incident. During separate interviews, the Acting Administrator and Regional Manager indicated the expectation in the home was for care to be provided to all residents as was specified in their plan. It was further verified that PSWs #108 and #109 had not provided care to residents #004 and #005, as was specified in their plans.

Sources: Resident #004 and #005's written plans of care; interviews with the Acting Administrator and the Regional Manager.
(672)

2. The licensee has failed to ensure residents #002, #006 and #007 received care as was specified in their plans.

Two Critical Incident Reports were submitted to the Director regarding allegations of staff to resident abuse and neglect, involving PSWs #103, #104, #105 and residents #002, #006 and #007. The first CIR indicated PSW #105 alleged PSW #103 did not provide care as required. The second CIR indicated PSW #104 alleged PSW #103 abused residents while providing care, including resident #002.

Review of the internal investigation notes indicated PSW #103 reported an identified number of staff would provide personal care to resident #002. Review of resident #002's written plan of care and MDS Assessment indicated the resident required a different level of care provided by a different number of staff members. The internal investigation notes further indicated PSW #103 reported residents would receive an identified intervention. Review of the internal Continence Care Program and during separate interviews, the Acting Administrator and Regional Manager indicated the expectation in the home was for residents to receive a different identified intervention. The Acting Administrator and Regional Manager further indicated the expectation in the home was for care to be provided to all residents as was specified in their plan. PSWs #103 and #104 were no longer employed in the home, therefore could not be followed up with related to the alleged incidents.

Sources: Resident #002's written plan of care, MDS Assessment and other identified documentation; internal policy related to continence care; internal Revera Continence Care Program and interviews with PSW #105, the Acting

Administrator and Regional Manager.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents related to the possibility of residents acquiring areas of altered skin integrity related to not receiving continence care as specified in their plan and/or possibly sustaining injuries or pain related to not receiving repositioning and mobility support as was specified in their plan.

Scope: The scope of this non-compliance was widespread, as more than three residents inspected upon were found to not have received care as was specified in their plan.

Compliance History: A Voluntary Plan of Correction was issued to the home during Critical Incident System Inspection #2021_715672_0026, issued to the home on August 11, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 3rd day of November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Batten

Service Area Office /
Bureau régional de services : Central East Service Area Office