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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 17, 2024	
Inspection Number: 2024-1335-0001	
Inspection Type: Proactive Compliance Inspection	
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: Fenelon Court, Fenelon Falls	
Lead Inspector Sheri Williams (741748)	**Inspector Digital Signature** Sheri A Williams Digitally signed by Sheri A Williams Date: 2024.07.24 14:10:28 -04'00'
Additional Inspector(s) Nicole Jarvis (741831)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19 -21, 24 - 28, 2024

The following intake(s) were inspected:
- Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

During two observations in a specified home area, the shower combination room was observed open and unlocked. Inside the unlocked room was observed medical equipment including oxygen, in addition to sharps containers and chemical disinfectant.

The IPAC Lead acknowledged that it was the expectation of the home that the doors for tub and shower areas to be kept closed and locked at all times. The staff

indicated they were aware that the shower combination room is to be locked at all times.

Failing to ensure the shower combination room was kept closed and locked posed a safety risk to residents that residents could access medical equipment and supplies.

Sources: Observations in the home, interviews with IPAC Lead and staff. [741748]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

1.The licensee shall ensure that the care set out in the plan of care was provided to a resident as specified in the plan of care.

Rationale and Summary

During an observation of a resident they did not have their medical device applied and were not groomed while sitting in the lounge prior to breakfast service.

A plan of care review indicated that the resident exhibits responsive behaviours as evidenced by resistive to care due to their medical diagnoses and directed staff to ensure they were wearing their medical device before providing care. Staff indicated that the resident requires their medical device prior to care being provided.

By failing to ensure the plan of care was provided to a resident as specified in the plan of care put the resident at risk of undue emotional and mental distress during personal care.

Sources: Observations of resident, and staff interviews. [741831]

2.The licensee shall ensure that the care set out in the plan of care was provided to a resident as specified in the plan of care.

Rationale and Summary

An identified resident was at a moderate risk for falls. Their plan of care included several interventions to prevent or minimize the risk of a fall. One of resident's fall interventions included wearing nonslip socks / shoes. During several different observations, there were no indication of the resident wearing shoes or nonslip socks.

Staff confirmed providing care to the resident on one of the occasions and indicated they did not see nonslip socks available to put them on. The Assistant Director of Care indicated that the home provides the nonslip socks for the residents.

By failing to shall ensure that the care set out in the plan of care was provided to the resident as specified in the plan put the resident at an increased risk of falls.

Sources: Observations of resident, resident's clinical record review, and staff interviews [741831]

3.The licensee shall ensure that the care set out in the plan of care was provided to

a resident as specified in the plan of care.

Rationale and Summary

During an observation, a resident was sitting on towels in their wheelchair without a sling under them, and without their medical therapy in place . A plan of care review indicated that the resident requires a medical device continuously and they are required to sit on a sling.

Staff acknowledged the home expects staff to follow the plan of care and expects staff to look at the resident's care plan. Staff indicated that the plan of care for the resident requires continuous medical device. The resident was observed with their medical device applied ten minutes later in the dining room.

Staff indicated that the plan of care for the resident was to have a sling under them but acknowledged that the resident may have been sitting on towels if it was their bath day.

By failing to ensure the plan of care was provided to a resident as specified in the plan of care put the resident at risk of medical issues.

Sources: Clinical health records of resident, observations and staff interviews. [741748]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary

A resident's written plan of care directed that appropriate footwear was to be worn daily; ensure laces are tied.

During observation of the resident, the resident was in a wheelchair and did not have any shoes on. Staff indicated that the resident was not wearing shoes at this time because of altered skin integrity.

By failing to ensure that a resident was reassessed, and the plan of care reviewed and revised at any time when the resident's care needs change put resident at risk for further altered skin or discomfort.

Sources: Observations of resident, resident's clinical record review, and staff interviews [741831]

WRITTEN NOTIFICATION: Communication and Response System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed, and used by residents, staff and visitors at all times;

The licensee failed to ensure that the resident-staff communication and response system could be easily accessed and used by a resident at all times.

Rationale and Summary

During a Proactive Compliance Inspection, a resident was observed on two occasions without access to their call bell.

On the first occasion, the resident was observed lying in bed with the bed in the lowest position and both side rails up, the call bell was observed hanging from the wall outside of the resident's reach. When asked by the inspector how they asked for assistance if they needed it, the resident attempted to reach the call bell but was it was out of their reach.

On the second occasion the resident was seated in their wheelchair in their room, beyond the foot of their bed, and the call bell was hanging beside the bed on the wall.

The care plan indicated the resident had an intervention for falls prevention to ensure that the call bell was within the reach. The care plan also indicated that resident required assistance from staff to move in their wheelchair.

In an interview, the staff indicated that the call bell should be in reach for all residents when they are in their room when they are able to use them. Staff acknowledged that the resident should have their call bell within their reach as part of their plan of care for their safety.

Failing to ensure that the call bell could be accessed for the resident-staff communication and response system posed a safety risk to the resident.

Sources: Observations, care plan for resident, and staff interviews. [741748]

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary

During observations, several residents had a mechanical lift sling left under them while in the wheelchair during different occasions and days.

Staff indicated that a resident was sitting on a bath sling in their wheelchair, because the resident was schedule to have a bath after breakfast, so it was easier to leave it under the resident. The resident's plan of care was reviewed and there was no indication that it was the resident's preference, or they required the sling to be left under them.

The Assistant Director of Care provided the manufacturer's instructions for use of the Arjo Passive Clip Slings.

The passive loop slings from Arjo Safety Instructions indicate that "patients sat out in a chair are at an increased risk of pressure injury development, due to high interface pressures concentrated over a small surface area when compared to lying in bed. An individualized skin and holistic assessment of the patient should be undertaken, before deciding on whether a sling should be left under a patient for any period of time."

The Director of Care indicated there was no process to monitor these potential areas of pressure points as the expectation is that the Arjo Passive Clip Slings are not left under the residents while in a wheelchair.

By failing to ensure all staff use equipment, specifically the mechanical slings, in accordance with Manufacturer's instructions, put the resident and other residents at an increased risk of altered skin integrity.

Sources: Observations, Manufacturer's instructions, and interview with the Director of Care. [741831]

WRITTEN NOTIFICATION: Dress

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 44

Dress

s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and keeping with the resident's preferences.

Rationale and Summary

During dining room observations, a resident was observed in their wheelchair wearing a t-shirt and a continence brief.

Staff noticed the resident just wearing a brief and covered the resident with a blanket found beside the resident on the ground. During an interview, the staff indicated that the resident was up in their wheelchair from the night shift and was wearing a hospital gown.

Staff indicated that the family did not like the resident in a hospital gown, so they assisted the resident with putting on a t-shirt. They did not assist the resident getting fully dress because they said the resident was going to have a bath after breakfast. Staff indicated they covered the resident with a blanket.

The resident's plan of care did not indicate the resident's preference to be in a t-shirt and brief during the meal service. The Director of Care indicated that it would not be appropriate to bring a resident to a meal service in a t-shirt and brief.

By failing to shall ensure that a resident was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing put the resident at risk experiencing indignity.

Sources: Observations, resident record review, and staff interviews. [741831]

WRITTEN NOTIFICATION: Food Production

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

1.The licensee failed to communicate to residents and staff menu substitutions.

Rationale and Summary

During an observation, the menu posted for the day listed chicken barley soup and wild raspberry macaroon bars for dessert, on the menu for that day.

Staff were overheard offering residents chicken barley soup. Once the soup was served staff told residents that it was actually Italian wedding soup. At the end of the meal staff were observed offering date squares to residents as a dessert.

Staff indicated that it was the expectation of the home to communicate menu substitutions to the staff and residents of the home and that this was not done.

Failing to ensure that residents are communicated menu substitutions in the home posed risk for dissatisfaction to residents with the quality and choice of the food production of the home.

Sources: Observations of menu posted in the home, meal service and interview with staff. [741748]

2. The licensee failed to ensure they communicated any menu substitution to the residents.

Rationale and Summary

During a meal observation, staff indicated there was a substitute to the menu, specifically the dessert.

The District Manager indicated that any menu substitutions are required to be communicated to the residents by updating the display daily menu in the resident dining room.

The menu did not reflect the substitution during meal service observations.

By failing to ensure the food production system communicates to residents of any menu substitutions did not provide a direct risk to the residents.

Sources: Observations, menu review, and staff interviews .[741831]

WRITTEN NOTIFICATION: Food Production

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (a)
Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service;

The licensee has failed to comply with their policies, and procedures for the safe cleaning of equipment related to dining service.

Rationale and Summary

The Servery Food Temperature Policy directs a Dietary Aid to wash and sanitize the thermometers after each use at point of service.

During observations, dietary staff dipped the thermometer in a red bucket after use. Observations during a different occasion, dietary staff dipped the thermometer in a green bucket and then into a red bucket before obtaining the temperature of the next food item.

The dietary staff indicated they were required to use the green bucket first with soap and water to clean and the red bucket to disinfect the thermometer after each use.

The Food Service Manager indicated they were directed to use a bucket with the soap and water (green bucket) with the use of a cloth to wipe the thermometer and then use a disinfectant solvent (red bucket) with the use of a clothe to wipe the thermometer and then shake off the excess liquid prior to use. The Food Service Manager indicated that the disinfectant was food safe, and the contact time was about a minute.

By failing to comply with the licensee's Servery Food Temperature Policy put the residents at risk when not properly cleaning the thermometer and cross contaminating the food products.

Sources: Observation, Servery Food Temperature Policy, and staff interviews.

[741831]

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (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:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee failed to ensure that the home provided a course-by-course service meals for each resident, unless other wise indicated by the resident or by the resident's assessed needs.

Rationale and Summary

Observations were made during breakfast in a specified home area. Several residents were provided their hot breakfast prior to finishing their cereal.
Two residents were served their hot breakfast prior to them receiving complete assistance with their cereal.

The Director of Care indicated the expectation was for the meal to be served to the resident's course by course.

By failing to ensure residents were served their meal course by course, created a risk of having poor intake of food items.

Sources: Observations, clinical record reviews, and staff interviews. [741831]

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure no resident who requires assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary

Observations were made of breakfast in a specified home area. A resident was provided cereal, and no assistance was provided to the resident. A co-resident was observed attempting to assist the resident by encouraging and lifting the spoon to feed them. During the meal serve a staff member got up several times to assist with other meal service duties leaving the resident to wait for their return. The resident's plan of care indicated they required extensive to total dependence while eating or drinking.

A resident's hot cereal was placed on the table approximately five minutes prior to the resident being assisted to the dining room by an activity aid. When the resident arrived, the staff member assisted them with eating. Two residents were provided their cereal without setup or assistance. Their food sat on the table until a staff member was able to assist.

The Director of Care indicated the expectation was for the meal to be served to the residents when they were ready to eat or when staff were available to assist the resident to eat.

By failing to ensure residents were not served their meals until a staff member was available to provide the required assistance, residents were placed at risk of having poor intake of both food and fluid items.

Sources: Dining room observations, resident's clinical record review, and staff interviews. [741831]