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
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Original Public Report

Report Issue Date: November 13, 2024

Inspection Number: 2024-1335-0003

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: Fenelon Court, Fenelon Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 22-25, 28-31, 2024 and November 1, 2024.

The following intake was inspected in this complaint inspection:

- One intake related to concerns regarding improper assessment and care of a resident.

The following intake was inspected in this Critical Incident (CI) inspection:

- One intake relate to an incident that caused injury and a significant change for a resident.

The following intakes were inspected:

- Follow-up to Compliance Order (CO) #002, related to FLTCA, 2021-s. 34(1)3 Protection from certain restraining with compliance due date (CDD) on August 9, 2024.
- Follow-up to CO #004, related to FLTCA, 2021-s. 5 Safe and Secure home with CDD on August 9, 2024.
- Follow-up to CO #005, related to FLTCA, 2021-s. 6(7) Plan of Care with CDD on August 9, 2024.

- Follow-up to CO #008, related to O. Reg. 246/22-s. 102(2)(b) Infection Prevention and control with CDD on August 9, 2024.
- Follow-up to CO #006, related to O. Reg 246/22 -s. 56(2)(g) Continence care and bowel management with CDD on August 9, 2024.
- Follow-up to CO #003, related to O. Reg. 246/22-s. 57(2) Pain management with CDD on August 9, 2024.
- Follow-up to CO #007, related to O. Reg. 246/22-s. 98(2)(a) Designated lead — housekeeping, laundry, maintenance with CDD on August 9, 2024.
- Follow-up to CO #001 related to FLTCA, 2021-s. 24(1) Duty to Protect with CDD on August 9, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1335-0002 related to FLTCA, 2021, s. 34 (1) 3. inspected by the inspector.
Order #004 from Inspection #2024-1335-0002 related to FLTCA, 2021, s. 5 inspected by the inspector.
Order #005 from Inspection #2024-1335-0002 related to FLTCA, 2021, s. 6 (7) inspected by the inspector.
Order #006 from Inspection #2024-1335-0002 related to O. Reg. 246/22, s. 56 (2) (g) inspected by the inspector.
Order #003 from Inspection #2024-1335-0002 related to O. Reg. 246/22, s. 57 (2) inspected by the inspector.
Order #007 from Inspection #2024-1335-0002 related to O. Reg. 246/22, s. 98 (2) (a) inspected by the inspector.
Order #001 from Inspection #2024-1335-0002 related to FLTCA, 2021, s. 24 (1) inspected by the inspector.

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #008 from Inspection #2024-1335-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected by the inspector.

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict

unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were locked in a way to restrict unsupervised access to those areas by residents, and those doors be kept closed and locked when they are not being supervised by staff.

Rationale and Summary
During a tour of the home, keys were observed to be hanging on a wall above a sensor pad that provides access to the service hallway. The service hallway doors were locked with signage noted on door stating "Staff Only". A key fob was observed to be on a lanyard above the sensor pad hanging on a screw.

A registered staff confirmed that the door leads to a service hallway which is a non-residential area. The registered staff indicated that this area was locked for resident safety to prevent access to potential hazards. The registered staff acknowledged that residents could wander in this area and there was risk for residents to enter the non-residential area due to having access to the keys.

By having keys stored in an area where residents can access them, failed to ensure that doors leading to non-resident areas were locked in a way to restrict unsupervised access to the area, the licensee placed residents at potential risk of harm.

Sources: Observations, interview with registered staff.

Date Remedy Implemented: October 25, 2024.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 has 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 complaint was received by the Director related to alleged improper assessment and care of a resident.

A resident required assistance with personal care. An incident occurred and the resident reported and experienced a worsening of health condition. As a result of the incident the resident required a specific therapy. Review of clinical records indicated that prior to the incident the resident had specific preferences for personal care.

The resident was assessed on move-in and was observed to have specific care needs. A plan of care was implemented for the resident that identified the resident care needs incorrectly. No further care plan revision related to specific care needs was made until after the incident.

The DOC indicated that they and the nursing team were responsible to review and

identify all residents with specific care needs. A PSW indicated that the resident's specific needs and their preferences for specified care, should have been included in their plan of care. The DOC acknowledged that the resident's care needs were not reflected in the plan of care and that the resident's plan of care related to specific care should have been reviewed and revised to reflect their care needs.

There was risk identified when resident's plan of care was not revised when the resident's care needs change or care set out in the plan is no longer necessary.

Sources: A CI, a resident 's clinical record, Quality/Risk Improvement Alert – Resident Safety, interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Conditions of licence

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with condition four of CO #008 with compliance due date of August 9, 2024.
Specifically, the licensee failed to make alcohol based hand rub (ABHR) accessible to health care providers, within each resident room, so that it is within arm's reach of the health care provider and they will not need to leave the zone of care to perform hand hygiene at the required moment by the compliance due date.

Rationale and Summary
Review of records provided by the home in relation to CO #008 condition four identified that several resident rooms were considered to have an obstruction for

the placement of additional ABHR.

Observation of resident rooms showed ABHR at entrance and exit of room and that ABHR was not within arms reach of the bed or bathroom.

An interview with the Associate Director of Care (ADOC) confirmed that ABHR was not within arms reach of point of care. An interview with the Executive Director (ED) acknowledged that a number of resident rooms have had no additional ABHR added at point of care.

By failing to comply with condition four of CO #008 the licensee placed residents at risk of harm due to potential for missed moments of hand hygiene by staff.

Sources: CO #008, room observations, resident room audit provided in compliance binder, and interview with ADOC and ED.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.