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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Public Report

Report Issue Date: September 11, 2025

Inspection Number: 2025-1335-0003

Inspection Type:
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 date(s): September 3, 4, 5, 8, 9, 10, 11 2025

The following intake(s) were inspected:

- Intake: #00152317 - Follow-up #: 1 - O. Reg. 246/22 - s. 267 (2) CDD August 22, 2025
- Intake: #00152482 - 2850-000008-25 - Fall of resident with injury
- Intake: #00153355 - 2850-000010-25 - Resident to resident sexual abuse resident
- Intake: #00155050 - 2850-000015-25 - Fall of resident with fracture

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1335-0002 related to O. Reg. 246/22, s. 267 (2)

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

Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Restraining by physical devices

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 5.
Restraining by physical devices
s. 35 (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee failed to ensure that informed consent for the use of a tilt wheelchair as a restraint was obtained from resident #001's substitute decision maker.

Sources: Critical incident report, resident's clinical record, home's policy Least Restraint Program, CARE10-O10.01, interview with Director of Care (DOC)

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee failed to ensure that strategies were implemented and care was coordinated to respond to a resident's responsive behaviours. Although specific medication monitoring was completed, it was not reviewed by the physician, contrary to the home's policy requiring physician evaluation of the monitoring tool to assess the

effectiveness of new medications. On a specific date, the Behavioural Support Ontario - Registered Practical Nurse documented negative side effects on the physician communication sheet, but there was no documented response from the physician. Furthermore, while a care conference was held with interdisciplinary team members present, the physician did not attend, and no collaborative review of the resident's medication occurred.

Sources: Resident's clinical record, Interview with BSO-RPN and DOC.

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee failed to ensure that procedures were implemented for cleaning the floor in the Sturgeon dining room to ensure that the floor was not sticky. The Environmental Services Manager (ESM) indicated that the floors are not washed after dinner and that dietary staff do spot cleaning if required as housekeeping staff leave at 3:00 p.m. The ESM indicated that dietary staff are not trained to clean floors or work with the required chemicals.

Sources: Critical Incident Report (CI), interviews with Executive Director (ED) and Environmental Services Manager (ESM)

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)

The licensee has failed to ensure that a resident was released from an assistive device and repositioned at least once every two hours. . The resident's plan of care did not provide interventions for the repositioning of the resident while they are in their assistive device.

Sources: observations of resident, resident's clinical record, interviews with DOC, Falls Lead, and RPN

WRITTEN NOTIFICATION: Medical directives and orders — drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 126 (a)
Medical directives and orders — drugs
s. 126. Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and

The licensee failed to ensure that medical orders for the administration of a specific medication, which requires careful monitoring due to the potential risks and side effects, were monitored and documented appropriately. The medication monitoring form was not initiated when a medication that required monitoring was prescribed on a specific date. As a result, the resident's behaviours were not captured in the monitoring process. The BSO RPN and Director of Care indicated that the monitoring sheet was

not started and acknowledged it should have been initiated in accordance LTCH policy.

Sources: Resident's clinical record, interview with BSO RPN and DOC.