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: February 27, 2026
Inspection Number: 2026-1335-0001
Inspection Type: Complaint Critical Incident
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): February 13, 17-20, 24-27, 2026

The following intake(s) were inspected:
- An intake regarding a complaint of improper care of a resident.
- An intake regarding alleged neglect of a resident by a staff.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

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. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

A Resident Home Area's living room was locked and unavailable to the residents. Inside the room there were empty boxes, a bed (with no mattress), a resident's walker, a desk in the middle of the room and several other items piled.

Sources: observations.

Date Remedy Implemented: February 18, 2026

WRITTEN NOTIFICATION: Right to quality care and self-determination

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 10.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
10. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop their potential and to be given reasonable assistance by the licensee to pursue these interests and to develop their potential.

A resident was not receiving physical support from caregivers to maintain their mental, social, and emotional well being and overall quality of life. Specifically, related to physical support the resident required to go outside.

Sources: resident's clinical records, and interview with resident.

WRITTEN NOTIFICATION: Right to an Optimal Quality of Life

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

A resident courtyard was observed to have significant accumulation of cigarette waste, with multiple full containers and numerous butts on the surrounding surface.

Sources: observations.

WRITTEN NOTIFICATION: Safe and secure

NC #004 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 designated outdoor smoking location was not maintained to ensure a safe and secure environment.

Sources: observations, the resident's clinical records and interviews.

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

An anonymous complaint was submitted to the Director regarding a Personal Support Worker (PSW) who allegedly told a resident that they would have to wait for assistance while the resident was expressing that they were unable to breathe.

During the inspection, several areas of non compliance were identified, demonstrating

that the licensee failed to protect the resident. These included:

• Compliance with manufacturers' instructions Written Notification with: O. Reg. 246/22, s. 26
• Policy to promote zero tolerance Written Notification with: O. Reg. 246/22, s. 103 (d).
• Licensee must investigate, respond and act Written Notification with: FLTCA, 2021, s. 27 (1) (a) (i)
• Responsive behaviours Written Notification with: O. Reg. 246/22, s. 58 (1) 2.

Sources: Critical Incident Report, internal investigation records, resident clinical records, and interview with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

A progress note indicated a resident was overheard by Registered Practical Nurse telling a co resident that someone comes in at night and engaged in inappropriate sexual contact.

The Registered Practical Nurse brought the allegation forward to management. The Long - Term Care Home did not immediately investigate to ensure the safety of the resident.

Sources: resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #007 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.

A resident's oxygen canister froze over when they were outside of the home. The manufacturers' instructions indicate the operating temperatures are -10C to 40C.

Sources: Critical Incident Report, internal investigation, and Oxygen Canister Specifications.

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

A resident's plan of care did not provide staff with clear guidance on meeting and managing the resident's needs, including written strategies on how to assess the resident, or techniques and interventions to prevent, minimize, or respond to responsive behaviours.

Sources: Critical Incident Report, internal investigation records, resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (d)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written

policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

A anonymous complaint was brought forward regarding a Personal Support Worker (PSW) telling a resident that they had to wait while they were expressing they were unable to breath.

The *Investigation of Abuse or Neglect Procedure* directs the long term care home to interview to conduct the investigation using the SBAR tool and root cause analysis checklist tool. The tool direction the investigator to interview all involved, including residents, staff and other involved.

Additionally, a PSW was not interviewed, despite being observed speaking with resident in the video footage of the incident.

Sources: Critical Incident Report, Long - Term Care Home's internal investigation records, Investigation of Abuse or Neglect procedure and interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

A resident received an administration of emergency medicated therapy, a pro re nata (PRN) prescription order was obtained the following day. It was subsequently determined the resident required ongoing medicated therapy.

There was no indication that the physician was contacted to update or clarify the order to reflect the continuous use of therapy the resident was requiring.

Sources: resident clinical records, and policy and procedures.