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

Ottawa District
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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: February 8, 2024
Inspection Number: 2024-1330-0001
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: Longfields Manor, Nepean

Lead Inspector	**Inspector Digital Signature**
Manon Nighbor (755)	Manon Nighbor Digitally signed by Manon Nighbor Date: 2024.02.08 10:36:41 -05'00'

Additional Inspector(s)
Saba Wardak (000732)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 31, 2024 and February 1, 2, 5, 6, 2024

The following intake(s) were inspected:

- Intake: #00107799 -Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management

Residents' and Family Councils
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
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 has failed to ensure that the home is a safe and secure environment for its residents.

Rationale and Summary:

A servery steam table and two cabinetry cupboards were found in a residents' common room.

In January, 2024, the inspector observed a steam table and two cabinetry

cupboards on the floor of a residents' common room.

On the same day, the Executive Director (ED) said that they were not aware that the steam table and two cabinetry cupboards were placed in the residents' common room and that they must have been placed there for a short period of time because of the kitchen renovation on another resident home area (RHA). They stated that residents do not use this resident designated room and these were removed from the room immediately.

As such, the sink and cabinetry, potentially may have caused a tripping hazards to residents.

Sources: Inspector #755's observations and interview with the ED.
[755]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 a door leading to a non-resident area was kept locked.

Rationale and Summary
In January 2024, a non-resident area door was observed to be unlocked and accessible without a key. The room was being used as a storage area for incontinent products and a call bell was not observed inside the room. Staff members were not present in this non-resident area at the time of observation.

On the same day, a Registered Practical Nurse (RPN) confirmed that the storage room door should be locked and should not be accessible to residents.

Failing to ensure the storage room door was locked, created a risk for residents with independent mobility to have unsupervised access to this area.

Sources: Observations on a specific RHA and interview with RPN.
[000732]