**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central East Service Area Office**
33 King Street West, 4th Floor
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**Original Public Report**

**Report Issue Date** June 21, 2022
**Inspection Number** 2022_1356_0001
**Inspection Type**
☐ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc.
**Long-Term Care Home and City**
Winbourne Park, Ajax

**Lead Inspector**
Amandeep Bhela (746)

**Additional Inspector(s)**
Eric Tang (529)
Asal Fouladgar (751)

**Inspector Digital Signature**
Amandeep Bhela
Digitally signed by Amandeep Bhela
Date: 2022.06.29 12:30:40 -04'00'

## INSPECTION SUMMARY

The inspection occurred on the following date(s): May 18-20, 24-27, 2022

The following intake(s) were inspected:

- Intake #006765-22 (Follow- up) related to Abuse
- Intake #006766-22 (Follow- up) related to Dining
- Intake #006767-22 (Follow- up) related to Medication Management
- Intake #006768-22 (Follow- up) related to Infection Prevention and Control

### Previously Issued Compliance Order(s)

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

| Legislative Reference | | Inspection # | Order # | Inspector (ID) who complied the order |
|---|---|---|---|---|
| LTCHA, 2007 | s. 19 (1) | 2022_673672_0006 (A2) | #002 | Eric Tang (529) |
| O. Reg. 79/10 | s. 73 (1) | 2022_673672_0006 (A2) | #003 | Amandeep Bhela (746) |
| O. Reg. 79/10 | s. 129 (1) | 2022_673672_0006 (A2) | #004 | Amandeep Bhela (746) |

| | | | | |
|---|---|---|---|---|
| O. Reg. 79/10 | s. 229 (4) | 2022_673672_0006 (A2) | #005 | Eric Tang (529) |

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION [DINING AND SNACK SERVICE]

**NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

Non-compliance with O. Reg 246/22, 79 (1) 9

The licensee had failed to ensure that proper techniques of safe positioning were used when assisting resident #012 with their meal.

**Rationale and Summary**

An observation was conducted for resident #012 during lunch, where PSW #115 was observed assisting the resident with their meal. During this observation it was noted that the resident was positioned in an unsafe position, as PSW #115 continued to feed the resident. Inspector #746 intervened to ask PSW #115 if it was safe to continue to feed the resident in this position. PSW #115 indicated that this is how the resident is. INSP #746 asked PSW to stop feeding the resident and verify with the nurse on the unit. PSW #115 and RPN #116 approached the resident, acknowledged the position, and indicated that this is how the resident is, at this time meal service had ended.

A review of the residents written plan of care indicated that staff are to ensure that resident is in an upright position for better swallowing and to ensure that the resident is positioned properly.

A second observation of the resident was conducted, during lunch where the resident was observed in an upright position, as they were bring assisted with their meal. Interviews were conducted with PSW #115 and RPN# 116 where they acknowledged the difference in the resident's position, and they acknowledged that the resident should not have been fed in an unsafe position. Interview with DOC was conducted, where they acknowledged that there could be a risk for the resident to choke if they are not positioned appropriately.

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Sources: clinical record review of resident #012, observations and interviews with PSW#115, RPN#116 and the DOC. [746]