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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 17, 2023
Inspection Number: 2023-1335-0001
Inspection Type: Complaint Critical Incident System
Licensee: AXR Operating (National) LP, by its general partners
Long Term Care Home and City: Fenelon Court, Fenelon Falls

Lead Inspector	**Inspector Digital Signature**
Patricia Mata (571)	Patricia Mata Digitally signed by Patricia Mata Date: 2023.08.18 16:34:58 -04'00'

Additional Inspector(s)
Catherine Ochnik (704957)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17 -21 and 24-28, 2023.

The following intake(s) were inspected:
Intake #00006449 and 00006542 – complaint related to improper care and neglect.
Intake #00086052 – complaint – related to improper care, abuse, neglect, and staffing level.
Intake #00004596 – related to a fall resulting in injury with a significant change in condition

The following intake(s) were completed in this inspection: Intake #00003207.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 229 (7)

The licensee failed to implement surveillance protocols for COVID-19, as specified by the Director in Directive #3.

Summary and Rationale

According to Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, effective July 16, 2021, under the heading “Required Infection and Prevention Control (IPAC) Practices” section three, "Daily Symptom Screening of All Residents", homes must ensure that all residents were assessed at least once daily for signs and symptoms of COVID-19, including temperature checks. Any resident who presented with signs or symptoms of COVID-19 must immediately have been isolated, placed on Droplet and Contact Precautions, and tested for COVID-19 as per the "COVID-19: Provincial Testing Requirements Update".

A complaint was submitted to the Director alleging improper care of resident #002.

A review of a resident’s clinical records indicated that the resident displayed signs and symptoms of COVID-19 and was put on isolation. Isolation precautions were discontinued the next day. Registered nursing staff believed that the resident did not have COVID-19 but rather a different infection and treatment was started for that infection. The resident continued to feel unwell. Three days after the resident displayed signs and symptoms of COVID-19, the resident expired. No evidence that a test for COVID-19 could be found.

In separate interviews, two Registered Nurses were unable to confirm if a test to rule out COVID-19 was collected.

No evidence was found to support that a rapid antigen test or PCR test was collected to rule out a COVID- 19.

By not keeping the resident isolated and testing for COVID-19, the licensee placed the other residents at

risk for infectious diseases including COVID-19.

Sources: Resident #002 progress notes, interviews with RN #108 and 110, and lab records for resident #002. [571]

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