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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: December 14, 2023.
Inspection Number: 2023-1106-0003
Inspection Type: Proactive Compliance Inspection
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Oak Terrace, Orillia

Lead Inspector	**Inspector Digital Signature**
Amanda Belanger (736)	Amanda Lee Claire Belanger Digitally signed by Amanda Lee Claire Belanger Date: 2023.12.14 14:48:31 -05'00'

Additional Inspector(s)
Steven Naccarato (744)
Amy Geauvreau (642)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20-23, 2023.

The following intake(s) were inspected:

- one intake related to a PCI Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Residents' and Family Councils
Medication Management
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: Windows

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

The licensee has failed to ensure that resident windows did not open more than 15 centimeters (cm).

Rationale and Summary
During the initial tour of the home, the Inspector noted that a resident's window opened 17cm.

The Environmental Service Manager (ESM) measured and confirmed that the window opened greater than the 15cm allowed.

There was low impact to the residents as a result of the window opening greater than 15cm.

Sources: Inspector observation; and, interview with the ESM

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WRITTEN NOTIFICATION: IPAC Standards

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee did not ensure all routine practices and additional precautions were followed in the IPAC program by staff and residents regarding the proper use of Personal Protective Equipment (PPE), including appropriate selection and application, as was required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary
The Inspector observed two staff exit a resident's room who required additional isolation precautions. The staff members did not have the required PPE on while in the room.

The IPAC lead confirmed that staff were to wear specific PPE when interacting with residents on additional isolation precautions.

There was low risk of impact to the residents, as the home was in an outbreak at the time of the non-compliance.

Sources: Inspector observations; and, interview with the IPAC lead, and other relevant staff.

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WRITTEN NOTIFICATION: Immediate Reporting of Outbreak

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately notified of the

disease outbreak.

Rationale and Summary
The licensee declared a Covid-19 outbreak for the home, however, did not complete the Critical Incident (CI) report until the next day.

The Executive Director (ED) indicated that they did not immediately notify the Director of the Covid-19 outbreak.

There was no impact to residents as a result of the outbreak not being immediately reported to the Director.

Sources: CI report; and, interview with the ED.

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