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
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Original Public Report

Report Issue Date: February 15, 2024	
Inspection Number: 2024-1106-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Oak Terrace, Orillia	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature** Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2024.02.20 16:18:51 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5- 8, 2024

The following intake(s) were inspected:

- One intake, which was an allegation of Improper/Incompetent treatment of a resident; and,
- One intake, which was an allegation of neglect of a resident.

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident had occurred, immediately reported the suspicion and information upon which it was based to the Director.

Rationale and summary
A Critical Incident (CI) report was submitted to the Director for an allegation of improper or incompetent treatment or care of a resident, two days after the incident occurred.

A Registered Nurse (RN) stated they had not reported the allegation to the on-call manager. The Director of Care (DOC) verified that the allegation of improper care

was not reported to the Director immediately.

Not reporting the allegation of improper care to the Director had a low impact and low risk to the resident.

Sources: A CI report; the home's investigation notes; interviews with an RN, and the DOC.
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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident had occurred, immediately reported the suspicion and information upon which it was based to the Director.

A CI report was submitted for an allegation of resident neglect that occurred the previous day.

The DOC verified that the allegation was not reported immediately as management only became aware the following day. The DOC stated that Registered staff should

have called the on-call manager right away so that they could have notified the Director.

Not reporting an allegation of neglect to the Director immediately presented a low risk and impact to the resident.

Sources: A resident's plan of care; the home's investigation notes; interviews with PSW and Registered staff; and the DOC.
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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when transferring a resident.

Rationale and summary
A resident's care plan at the time of the incident, stated that the resident required a specified level of assistance and device for transferring. A PSW had not followed the plan of care when they transferred the resident.

A PSW and the DOC verified that the resident was not transferred by the PSW using safe transferring techniques.

There was a moderate risk to the resident when staff did not use safe transferring techniques as there was potential for injury to the resident.

Sources: A CI report; a resident's care plan; the home's investigation notes; interviews with PSW staff, an RN, and the DOC.
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WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident, who required continence care products, was provided with sufficient changes to remain clean, dry and comfortable.

There had been an allegation of neglect related to a resident not receiving continence care for a specified period of time. The resident also stated that they had not received continence care for the specified period of time.

The resident's plan of care identified that the resident required a specified level of assistance for continence care; however, did not specify when staff were to provide the assistance. The home's investigation verified that the resident did not receive

any continence care for a number of hours.

PSW and Registered staff verified that the resident required the specified level of assistance and that they should have been provided with assistance during that period of time. The DOC verified that the resident had not received the required continence care and that they should have.

There was a moderate risk related to the resident not receiving the assistance that they required to remain clean, dry and comfortable.

Sources: A resident's plan of care; the home's investigation notes; interviews with PSW and Registered staff; and the DOC.
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