

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007****Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée****Long-Term Care Operations Division  
Long-Term Care Inspections Branch****Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**Central East Service Area Office  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 25, 2021	2021_718751_0001	002480-21	Other

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**Licensee/Titulaire de permis**Revera Long Term Care Inc.  
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4**Long-Term Care Home/Foyer de soins de longue durée**Thorntonview  
186 Thornton Road South Oshawa ON L1J 5Y2**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

ASAL FOULADGAR (751)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct an Other inspection.**

**This inspection was conducted on the following date(s): February 23, 2021, as an off-site inspection.**

**During this inspection the following intake was inspected:  
Log # 002480-21 related to infection prevention and control.**

**During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care (DOC).**

**During the course of the inspection, the inspector also conducted record reviews.**

**The following Inspection Protocols were used during this inspection:  
Infection Prevention and Control**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister**

**Specifically failed to comply with the following:**

**s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.**

**Findings/Faits saillants :**

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The licensee failed to comply with the Minister's Directive: "COVID-19: Long-term care home surveillance testing and access to homes", effective January 8, 2021, and updated on February 16, 2021, when an untested staff member entered the home. The home is located at Durham Region health unit which was included in the province-wide shutdown effective December 26, 2021, and then moved into the red zone as of February 16, 2021.

According to the surveillance report the Ministry of Long-term care (MLTC) received from the home on an identified date, one staff member who missed the swabbing clinic entered the home and passed through the screening process on multiple occasions. In an interview with DOC #100, they confirmed that the staff member did not have their test done at the home's swabbing clinic on two identified consecutive weeks and entered the home during that time. The staff member was tested positive during the time they had entered the home and as a result, the home was declared to be in an outbreak by public health unit. No residents were affected during this outbreak.

By failing to ensure the staff member being tested prior to entering the home, there was a risk of transmission in the home.

Sources: Mandatory Data Reporting submitted to the Ministry's Health Data Collection service website weekly by the home. Minister's directive: "COVID-19: Long-term care home surveillance testing and access to homes", dated January 8, 2021, and updated on February 16, 2021. Interviews with DOC #100 and Administrator #101.

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every staff working in the home take Antigen Tests or PCR Tests in accordance with and at the frequency prescribed in the Minister's Directive: "COVID-19: long-term care home surveillance testing and access to homes", to be implemented voluntarily.***

**Issued on this 25th day of February, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**