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: October 18, 2023	
Inspection Number: 2023-1060-0003	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Eagle Terrace, Newmarket	
Lead Inspector Maria Paola Pistritto (741736)	**Inspector Digital Signature**
Additional Inspector(s) Lucia Kwok (752) was also present.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11, 12, 13, 14, 20, 2023
The inspection occurred offsite on the following date(s): September 15, 2023

The following intake(s) were inspected:

- One Intake related to staff to resident abuse.
- One intake related to an infectious outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021 s. 3 (19) (iv)

The licensee has failed to ensure that a resident’s personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential in accordance with the Act.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director for an infectious outbreak. During the initial tour, Inspector #741736 observed a resident in a private room with infectious signage on the door. The Infection Prevention and Control (IPAC) Lead confirmed they were not aware the display of infectious positive signage identified the resident's diagnosis and their personal health information (PHI).

Failure to protect the resident’s PHI by identifying the diagnosis on a resident room door, exposes the resident's privacy.

Sources: Observation and interview with IPAC Lead. [741736]

Date Remedy Implemented: September 12, 2023

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure strategies were implemented to respond to responsive behaviours experienced by the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an alleged staff to resident abuse. The plan of care indicated that the resident expressed behaviours as a part of their disease process. The care

plan indicated if the resident was restless/agitated during care, stop and re-approach in a few minutes with assistance from other staff as needed.

Personal Support Worker (PSW) #101 confirmed that care did not stop when the resident was being resistive to care. PSW #101 could not identify behavioral interventions for the resident. PSW #101's response to the resident's pinch was not appropriate and not according to the care plan. PSW #109 confirmed the resident was being resistive to care and was not re-approached. Behaviour Support Ontario (BSO) Lead confirmed that PSW #101's response to the resident when they expressed behaviors.

Failure to implement appropriate interventions for behaviours contributed to the resident's injury.

Sources: Resident's clinical notes and interviews with staff. [741736]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that a resident's responsive behavioral needs were met by the lack of reassessments of interventions and the documented response of the resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an alleged staff to resident abuse. The care plan identified interventions in place for behaviours and identified triggers. The plan of care indicated that the resident expressed behaviours as a part of their disease process. Review of the residents' chart did not disclose any assessments or reassessments of any current intervention.

The Behavioral Support Ontario (BSO) Lead confirmed the purpose of the monthly meetings was to discuss residents expressing behaviours. Review of monthly meeting minutes disclosed no discussion of the resident's behaviours or reassessment of interventions, even though they were displaying behaviours. The BSO Lead confirmed they do not keep documentation of reassessments nor the resident's response to interventions.

Failure to reassess behavioral interventions for the resident effects their quality of care received.

Sources: BSO monthly meeting notes and interview with BSO Lead. [741736]

COMPLIANCE ORDER CO #001 Infection Prevention and Control Program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:

1) Educate Housekeeper #103 on the appropriate selection of PPE in additional precaution rooms.
    a. Education to be provided by the IPAC Lead
    b. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
2) Educate Physician #100 where the designated eating and drinking areas can be found during an outbreak.
    a. Education to be provided by the IPAC Lead
    b. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
3) Educate all Registered Staff on the second floor responsible for labeling resident rooms with additional precaution signage.
    a. Education to be provided by the IPAC Lead
    b. Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
4) Ensure an adequate supply of face shields for additional precaution rooms is always available.
5) IPAC Lead or Management designate to complete audits on the appropriate selection of PPE and precaution signage, once every shift on all shifts, three times a week for a period of 2 weeks. Keep a documented record of the audits.

Grounds

Non-compliance with: O. Reg. 246/22 s.102 (2) (b), IPAC Standard 9.1 (e) (i)

1) The licensee has failed to ensure accessibility of face shields at the point of care and the correct precaution signage on the resident’s door.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, section 9.1(e)(i) states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program including use of environmental controls, including but not limited to, location/placement of residents’ equipment, cleaning, making hand hygiene products available.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an infectious outbreak. During on-site inspection, Inspector #741736 observed incorrect signage placed for the type of additional precaution. The IPAC Lead confirmed that the incorrect signage was posted for the additional precautions. Inspector

#741736 observed multiple staff cross their clean field after donning Personal Protective Equipment (PPE) to retrieve face shields. The IPAC Lead confirmed this practice crossed the clean field and would be changed.

Inspector #741736 observed Physician #100 eating and drinking behind the nursing station on the second floor where other staff and residents were present.

Failure to display correct additional precaution signage on residents' rooms and staff eating and drinking outside of the designated areas puts residents at risk for infection during an outbreak. [741736]

Non-compliance with: O. Reg. 246/22 s.102 (2) (b), IPAC Standard, section 9.1 (f)

2) The licensee has failed to implement the appropriate selection of PPE when cleaning infectious rooms.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for an infectious outbreak. During on-site inspection, Inspector #741736 observed Housekeeper #103 cleaning an infectious positive room wearing a surgical mask under their shield. The IPAC Lead and Housekeeper #103 confirmed the personal protective equipment (PPE) expectation for that specific room included a gown, gloves, a shield and an N95 fitted mask. The signage on the door required an N95 mask to enter.

Failure to don appropriate PPE puts residents at risk for infection.

Sources: Observation and interview with staff. [741736]

Non-compliance with: O. Reg. 246/22 s.102 (2) (b), IPAC Standard, section 6.1

3) The licensee has failed to make face shields accessible at the point of care to all staff.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, section 6.1 states that the licensee shall make PPE available and accessible to all staff.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the director for an infectious outbreak. During onsite inspection, Inspector #741736 observed multiple staff cross their clean field after putting on PPE to retrieve their face shields that were located on the handrails in brown paper bags in the hallway. A tour

with the IPAC Lead confirmed that retrieving face shields after donning PPE crossed the clean field. The IPAC lead confirmed that this practice would be changed.

Failure of not having PPE equipment accessible to staff during an outbreak, puts residents at risk for infection.

Sources: Observations and interview with staff. [741736]

This order must be complied with by November 17, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.