Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date: December 5, 2022	
Inspection Number: 2022-1134-0001	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Fosterbrooke, Newcastle	
Lead Inspector Basel Mansour (741724)	**Inspector Digital Signature**
Additional Inspector(s) Julie Dunn (706026)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 8-14, 2022

The following intake(s) were inspected:

- Intake #00002614, CIS #2625-000005-22 was related to a controlled substance missing/unaccounted.
- Intake #00011629, CIS #2625-000009-22 was related to COVID-19 outbreak

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

Rationale and Summary
The licensee failed to carry out every operational or policy directive that applied to the long-term care home.
Specifically, the Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2020, when the home failed to ensure that staff are cleaning and disinfecting frequently touched surfaces more than once in outbreak areas.

Staff indicated that during an outbreak, frequently touched surfaces in residents' rooms are cleaned and disinfected only once per day.

IPAC lead indicated that during an outbreak, the home expectation is that housekeepers clean and disinfect residents' rooms' frequently touched surfaces more than once per day.

Record review of the home high-touch surfaces disinfecting log and Job routine checklist - housekeepers 1'st and 2'nd floor showed that frequently touched surfaces that are inside residents' rooms are cleaned and disinfected only once per day during a COVID-19 outbreak.

REVERA COVID-19 PLAYBOOK document shows that during enhanced measures, all high-touch areas are to be disinfected with increased frequency, at a minimum 2 times per day and when soiled.

During an outbreak, there is a potential risk of transmitting infectious diseases among residents, when frequently touched surfaces are not cleaned and disinfected more than once per day.

Sources: Interviews with staff; high touch surfaces disinfecting log, Job routine checklist - housekeeper 1'st and 2'nd floor, and REVERA COVID-19 PLAYBOOK. Critical Incident report # 2625-000009-22
[741724]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

Rationale and Summary
The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored

The home required staff to monitor symptoms indicating the presence of infections every shift.

Staff indicated that symptoms indicating the presence of infections should be monitored every shift and documented in residents' progress notes.

The public health line listing identified the onset of first symptoms for resident # 002 and # 003. Both residents were placed under additional precautions accordingly. However, record review of the residents' progress notes showed that symptoms indicating the presence of infections were not monitored every shift

There is a minimal risk that residents don’t receive timely intervention when the home did not monitor and document symptoms indicating the presence of infections every shift.

Sources: Interviews with staff; Resident # 002 and # 003 progress notes; and public health line listing [741724]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with O. Reg 246/22 s. 140 (2)

The licensee failed to ensure that a medication was administered to resident #001 in accordance with the directions for use specified by the prescriber.

Rationale and Summary:

Resident # 001 had an order for medication with specific prescribed instructions. There was a missed dose on a specific date, and the resident did not receive their medication as specified by the prescriber.

Impact and Risk:
There was no documented impact and the risk to the resident was low when the medication was not administered to the resident as prescribed.

Sources:
Interviews with staff; resident #001's clinical record; medication incident report.
[706026]