

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

Public Report

Report Issue Date: March 6, 2025

Inspection Number: 2025-1121-0002

Inspection Type:

Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: MacKenzie Place, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4-6, 2025

The following intake was inspected:

- An intake related to the alleged neglect of residents by a staff member.

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

- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

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Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that two residents received a specified medical intervention as ordered by the physician.

On a specified date, Registered Practical Nurse (RPN) #102 was observed to be experiencing difficulty with the completion of the morning medication administration, which included a specified intervention for two residents. No entries were made in either of the resident's electronic medication administration records (eMAR) to confirm completion. RPN #102 confirmed to the Director of Care (DOC) that they had failed to complete the task as ordered. One resident experienced a departure from their baseline as a result of the RPN failing to follow doctor's orders.

Sources: clinical records, eMAR for both residents for specified date, long-term care home's investigation notes, interview with DOC.

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