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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 14, 2025
Inspection Number: 2025-1121-0003
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): April 10, 11, 14, 2025

The following intake(s) were inspected:

- One intake related to Improper/incompetent care of residents by staff.

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

Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee had failed to ensure that the provision of the care set out in the plan of care was documented when identified assessments were not signed, for a resident on three occasions.

The home submitted a Critical Incident Report (CIR), that indicated a Registered staff member had failed to complete specific assessments for several residents.

A record review indicated that a resident had received a specific assessment on three occasions, however the Registered staff member had not signed the Administration Record to indicate completion.

The Associate Director of Care (ADOC) confirmed that the completion of the assessments had not been signed for on the identified dates.
Sources: CIR, Record review of the TAR, and other clinical records for the resident, and interviews with the ADOC. [647]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 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 had failed to ensure a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director, specifically improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

It had been identified by the home that a Registered staff member, had failed to complete resident specific assessments during an identified month. However, the home did not submit a CIR until almost two months after the incident for Incompetent treatment.

Sources: CIR, and interviews with the ADOC and the Executive Director (ED).

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee had failed to ensure a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A CIR had been submitted by the home to indicate that skin assessments had not been completed on various residents. A record review indicated that two identified

residents did not receive their scheduled skin assessments on two separate dates.

The ADOC confirmed that both residents had not received their scheduled skin assessments on the above days that the Registered staff member was assigned to complete.

Sources: CIR, review of clinical records, and interviews with the ADOC and ED. [647]

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