Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 9, 2023	
Inspection Number: 2023-1208-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Sara Vista, Elmvale	
Lead Inspector Katy Harrison (766)	**Inspector Digital Signature**
Additional Inspector(s) Kim Byberg (729) Mark Molina (000684) Blake Webster (000689)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-27, 2023.

The following intake(s) were inspected:

- Intake: #00005039, related to falls
- Intake: #00017592, related to abuse
- Intake: #00084496, and Intake: #00019679, regarding a complaint related to resident care
- Intake #00022722, related to staff qualifications.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee has failed to ensure that when a resident was exhibiting pain, they provided strategies to manage the pain, including non-pharmacologic interventions, equipment supplies, devices and assistive aids.

Rationale and Summary

A resident had an injury that caused acute pain. Their pain assessment post incident was six out of 10. No immediate medical or non-pharmacologic strategies were provided post incident.

A Registered Nurse (RN) stated that the resident had a medication ordered for pain which should have been given.

The resident was at risk for uncontrolled pain when staff did not treat their acute pain or complete any follow-up pain assessments until the next day.

Sources: Risk management tool, medication administration audit, pain assessment and symptom management policy program, pain assessment, RN interview. [000689]

COMPLIANCE ORDER CO #001 Staff Qualifications

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 73 (b)

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

a) Ensure that a record is kept for each staff member of the home that includes, verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.

b) Complete an audit of all registered staff files to ensure that the information is current and correct and corresponds with the information contained in the College of Nurses of Ontario (CNO) website.

The audit record must include:

i) When the audit was completed and the names of the people who completed the audit.
ii) The training record for the people completing the audit and verification process.
iii) A documented summary of the audit results must be kept in the home.

c) Ensure the people completing the audit, and the validation checks during the hiring process, are trained in the audit and verification process, including direction on steps to be taken if they are unable to verify the information.

Grounds
The Licensee has failed to ensure that a Registered Nurse possessed the qualifications provided for in the regulations.

The College of Nurses of Ontario (CNO) contacted the home and informed them that a former employee of the home was not licensed to practice as a Registered Nurse, as they were added to their list of unlicensed practitioners.

On hiring the staff member the home verified their qualifications on the College of Nurses of Ontario (CNO) website. When conducting the check, they failed to notice that the name on the website did not match the name on the employee's identification document, a copy of both were in the staff personnel file.

The Executive Director (ED) confirmed that the staff member worked at the home as a Registered Nurse without a nursing license. They said that the verification process was not followed correctly by the home and the information from the CNO that was included in the staff file was for the wrong person.

Failure to ensure the staff member had the proper skills and qualifications posed a high risk to residents.

Sources: Critical Incident System Reports, interview with Executive Director, Staff personnel file, homes internal investigation notes. [766]

This order must be complied with by May 19, 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.