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

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, 2024	
Inspection Number: 2024-1083-0004	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Thorntonview, Oshawa	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-27, and October 1- 4, 7, 2024.

The following intake(s) were completed in this inspection:

- Four intakes related to improper care of residents.
- Three intakes related to alleged abuse of residents.
- One intake related to an injury that resulted in a transfer to the hospital.
- One intake related to a COVID-19 outbreak.

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

Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

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. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the resident's care plan was updated when the resident's transfers needs changed, or care set out in the plan was no longer necessary.

Summary and Rationale

A Critical Incident Report (CI) was submitted to the Director, indicating that the resident had sustained an injury that resulted in a transfer to the hospital and change in their health status.

The care plan for the resident indicated they needed a transfer device and two staff members to assist with transfers during times of weakness. The Physiotherapist (PT) recognized that the care plan needed to be revised because the resident's transfer needs had changed, and they no longer required the specified interventions.

Personal Support Worker (PSW) and the RAI (Resident Assessment Instrument) Coordinator confirmed the resident previously required a specified transfer device and two staff members to assist for transfers following an injury, but their needs had since changed, and now only one staff member was needed.

The RAI Coordinator updated the care plan for the resident to reflect the resident's revised needs, noting that they now required limited assistance from one staff member and no longer needed a specific transfer device.

Sources: observations, clinical records for the resident, interviews with PSW, PT and RAI Coordinator.

Date Remedy Implemented: September 27, 2024

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure the home complied with their written policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

A CI was submitted to the Director related to an allegation of abuse towards a resident by another resident that was witnessed by a Registered Practical Nurse (RPN).

According to the home's resident non-abuse policy, anyone who became aware of or suspected abuse or neglect of a resident must immediately report that information to the Executive Director (ED) or, if unavailable, to the most senior supervisor on shift.

Further review of the home's adverse events reporting procedure, the front-line staff were to notify the ED or designate of an adverse effect, provide immediate action or care and document in the resident's records, follow reporting requirements, and investigate the event.

The RPN acknowledged that they reported the incident to another RPN but did not notify the ED or Director of Care (DOC), nor did they document the incident in the resident's records.

DOC and Assistant Director of Care (ADOC) confirmed that the home's policy was not followed when the RPNs who became aware of the abuse did not immediately notify the ED or designate and documented the incident on the resident's records to allow an immediate investigation.

Failure to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with immediately reporting the allegation of abuse and starting an investigation increased risk of continued abuse of other residents.

Sources: Resident Non-Abuse Policy, Adverse Events Reporting for Quality Improvement Activities Procedures, and interviews with RPN, ADOC and DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring devices when assisting a resident.

Rationale and Summary

A CI was submitted to the Director, indicating that a resident had sustained an injury resulting in a transfer to the hospital.

The resident's care plan stated that they used a mobility device's support when being transported for long distances. A PSW was observed pushing the resident's using mobility device from their room to the dining room without using the support. The PSW acknowledged that the intervention was outlined in the care plan but they did not follow it because the resident did not like it.

Separate interviews with the PSW and the PT indicated that staff must put the support on the resident's mobility device when being transported for longer distances.

Failing to use safe transferring devices for the resident placed them at risk of injury.

Sources: resident's electronic records, observations, interviews with PSWs and PT.

WRITTEN NOTIFICATION: Pain Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to assess and monitor the resident using a clinically appropriate assessment instrument when their pain was not relieved by initial intervention.

Rationale and Summary

A CI was received by the Director alleging non administration of pain medication for the resident.

A review of the resident's call bell history showed that the resident called multiple times on a specified date with the wait times ranging from nine minutes to over an hour due to experiencing pain.

A review of the Medication Administration Record (MAR) indicated the resident received scheduled pain medications prior to going to bed.

A review of the resident pain Pro Re Nata (PRN) administration indicated the resident received prescribed medication. However, there was no record of an assessment data using a clinically appropriate tool to assess the pain, and effectiveness of the medication administered.

The home's pain medication policy directed the nurse:
1. To screen residents for pain using a standardized evidence informed tool,
2. Residents with identified pain must have 72hrs pain monitoring initiated and completed,
3. The effectiveness of pain interventions is monitored, and residents' outcomes are evaluated and documented, and
4. To complete a comprehensive pain assessment for all residents who have identified pain.

The resident's clinical assessments records indicated, the resident was not screened using an evidence informed tool, a 72hrs pain monitoring was not initiated, and a comprehensive pain assessment was not completed for the resident.

The resident's pain monitoring sheet indicated no assessment or monitoring data recorded on the dates the resident complained of pain.

RPN confirmed the resident was not screened using an evidence informed tool, 72hrs pain monitoring was not initiated and a comprehensives pain assessment was not completed for the resident. However, the MAR questionnaire on the effectiveness of the medication was completed.

Failing to assess the effectiveness of pain interventions through comprehensive pain assessments placed the resident at risk of delayed treatment and worsening pain.

Sources: Resident's MAR, resident's clinical assessments records, home's policy Pain Assessment and Management Program, and interviews with RPN.

WRITTEN NOTIFICATION: Food production

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that a meal for a resident was served using methods to prevent adulteration, contamination and food borne illness.

Rationale and Summary

During an onsite inspection, it was noted that the breakfast tray for a resident was in their room at a room temperature for two hours after it was served. The resident indicated that did not feel like eating when the tray was served.

A PSW indicated that the tray was served after the meal service in the dining room, checked with the resident a few times, and left the tray in their room to not deny them any food.

According to the home's food temperature checklist procedure, for residents who had chosen not to attend meal service as scheduled and have requested that their meal be placed aside for consumption later that day; meal items will be plated as per the resident's plan of care, labelled (with the resident's name and date) and refrigerated immediately.

The Nutrition Manager (NM) indicated that the home's expectation was not to leave food served for two hours. If a resident didn't want the tray or the staff noted that after half an hour they didn't want to eat. The PSWs could request other items that were kept in safe temperatures.

Failing to serve meals to residents that did not preserve food safety put the resident at risk of consuming contaminated food that may cause food borne illness.

Source: Long Term Care Food Temperature Checklist Procedure, observations, interviews with the resident, PSW, and Nutrition Manager.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee failed to include the Ministry's toll-free telephone number and contact information for the patient ombudsman in the written response letters provided to a resident Substitute Decision Maker (SDM).

Rationale and Summary

A CI was submitted to the Director about an allegation of emotional abuse towards a resident by a staff member.

The resident's SDM emailed the home's ED indicating that a staff member took a long time to answer the call bell and spoke to them inappropriately. The ED emailed the SDM to acknowledge the complaint and to provide the outcomes of the investigation, respectively.

The response letters did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The ADOC and the DOC acknowledged the response letters did not include the aforementioned information.

Failing to include the information to contact the Director and the patient ombudsman may interfere with access for further support for residents and family.

Sources: CI report, home’s internal investigation, interviews with the ADOC and the DOC.

COMPLIANCE ORDER CO #001 Reporting certain matters to the Director

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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

a) Review the home's Resident Non-Abuse Policy and Mandatory Reporting of

Resident Abuse or Neglect Procedure. The policy must clearly specify the steps that anyone in the LTCH, including registered staff, must follow when they become aware of an allegation of abuse according to legislative requirements.

b) Ensure all registered nursing staff receive training related to FLTCA s. 28 (1) 2 where "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: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

c) Training must include the types of abuse, grounds to suspect abuse, and risk of harm

d) Keep a documented record of this training, including the date it was provided, content covered, trainer's information, and attendees. Ensure all documentation is readily available to the inspector.

Grounds
The licensee has failed to ensure that a PSW properly reported an observed incident immediately to the person in charge of the unit.

Rationale and Summary

During an interview, a PSW reported witnessing another PSW transfer a resident in a way that caused the resident to be injured. The PSW noticed the resident appeared to be in distress before leaving the room. They confirmed that they reported the incident to the charge nurse the same day but were unsure if the nurse acknowledged their report.

On their next shift, the PSW observed an injury on the resident and reported the incident to several nurses two days later. However, the PSW was uncertain whether the nurses received their report or interpreted it as a complaint. Management became aware of the incident five days later when the PSW described it to a registered staff member working on a different unit.

The alleged PSW recalled transferring the resident to bed with another PSW. However, they did not recall repositioning the resident by themselves, hitting the resident or heard them crying.

Interim DOC confirmed Management was made aware of the incident five days after the incident occurred; and the PSW was not specific with reporting what they saw, heard or felt in an appropriate way to the charge nurse of the unit on the day the incident occurred.

A review of the home's investigative records revealed documentations, investigations, and reporting of the incident started five days after the incident occurred. Also, assessments of the resident's injury started five days after the alleged incidents.

Revera's mandatory reports indicates were any person has reasonable grounds to suspect that any of the following has occurred or may occur, such person must immediately verbally report the suspicion and the information upon which it is based to the person in charge i.e. the nurse on duty.

Failure to ensure that an incident of alleged abuse from a staff member was appropriately reported to the charge nurse created a missed opportunity for the home to investigate, respond and take appropriate actions in a timely manner.

Sources: Interviews with staff, Record reviews of assessments, investigative record, CI report and Revera mandatory reporting of resident abuse and neglect policy.

The licensee failed to immediately notify the Director when a resident Substitute Decision Maker (SDM) reported an allegation of abuse.

Rationale and Summary

A CI was submitted to the Director about an allegation of emotional abuse towards a resident by a staff member.

The resident's SDM emailed the home's ED indicating that a PSW took a long time to respond to the resident's call bell and spoke inappropriately causing emotional distress to the resident. The Director was notified of the allegation eleven days later.

The DOC and the ADOC acknowledged that the allegation of abuse was not immediately submitted to the Director.

Failing to ensure that the Director was informed of any abuse allegations could have led to further risk for the resident.

Sources: CI report, home's internal investigation, and interviews with PSW, DOC and ADOC.

The licensee failed to immediately report to the Director an allegation abuse towards a resident.

Rationale and Summary

A CI was made to the Director about an allegation of abuse towards a resident. Record review related to the incident revealed that an RPN witnessed the abuse and reported the observation to their assigned RPN, but neither RPN reported the abuse to the ED or designate.

The home's resident non-abuse policy directed that anyone who became aware of or suspected abuse of a resident must immediately report that information to the ED or, if unavailable, to the most senior supervisor on shift. Further, the mandatory reporting of resident abuse or neglect procedure directed that the "Nurse" and "They" will then together immediately report the abuse to the Director. The procedure did not specify who "they" were. Another document called "the adverse events reporting algorithm" directed the staff that a confirmed abuse was considered an adverse event, so they were to follow this algorithm.

The RPN acknowledged that they did not immediately report their observations to the DOC or ED or document the incident in the resident's health records. Further, they didn't use the home's adverse events algorithm to report the abuse.

In an interview with the DOC and they ADOC, they learned about the incident from the 24-hour nursing report and not from any of the RPNs who became aware of the incident. Both confirmed that the allegation of abuse was not promptly reported to the Director.

Failing to ensure that the Director was informed of any abuse allegations could have increased the risk to the resident.

Sources: CI report, home's internal investigation, Mandatory Reporting of Resident

Abuse or Neglect Procedure, Adverse Events Reporting for Quality Improvement Activities, and interviews with RPN, DOC and ADOC.

This order must be complied with by January 31, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

a) Remove Personal Protective Equipment (PPE) garbage receptacles from the hallways.

b) Provide Anti-Bacterial Hand Rub (ABHR) at point of care to ensure it is easily accessible for staff to utilize to achieve the four moments of hand hygiene.

c) The IPAC Lead or trained designate shall conduct weekly audits once a week for four weeks to ensure staff are accessing and using ABHR appropriately at point of care. The home will keep a documented record of the audits which will include the name of the person completing the audit, the date it was completed, and any corrective actions made. Make the records available to the inspector immediately upon request.

d) The IPAC Lead or trained designate will provide education to all staff providing direct resident care, and meal service on the importance of hand hygiene and the four moments of hand hygiene.

This education will include but not be limited to an in-person scenario-based return demonstrations training. Documentation of the in-person scenario-based return demonstrations training must include:

• What education was provided.
• Who provided the education.
• Name of staff educated and their signatures.
• Date education provided.
• Outcome of return demonstrations

e) After the education has been provided the qualified IPAC Lead, or trained management designate is to conduct audits for hand hygiene for 6 weeks including holidays and weekends on every shift for staff hand hygiene practice. Keep a documented record of the audits completed, including the name of the person conducting the audit, the name of the staff being audited, any corrective actions, date of the audit.

f) The IPAC Lead will analyze the overall hand hygiene audit findings from the six-week period to identify trends and create an action plan if deficits are identified. A summary of this analysis and any related action plans will be made available to Inspectors, immediately upon request.

Grounds

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the licensee has failed to ensure that Routine Practices were followed in the IPAC program, specifically related to the completion of hand hygiene by multiple staff, in different home areas.

During the course of the inspection, the Inspectors observed multiple staff from different departments did not perform hand hygiene in accordance to the four moments of hand hygiene; in different areas of the home.

Failing to ensure the completion of hand hygiene as required increases the risk of transmitting infectious agents and places the residents at risk for contacting infectious disease.

Sources: Observations made by Inspectors, interviews with staff

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 percent (%) Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

During the initial tour of the home, the resident's rooms on the first, and second floors did not have access to ABHR at the point of care. Staff were observed accessing ABHR at the door and not at the point of care.

A PSW confirmed there are no ABHR at the point of care in every resident room and the expectation while providing care is for staff to access ABHR at the point of exit in the private and semiprivate rooms.

The IPAC lead indicated the four moments of hand hygiene could be achieve by using the ABHR at the point of exit in the semiprivate and private rooms, and staff were expected to carry ABHR with them when they were providing care. They also confirmed there were no ABHR at the point of care or within the care zone in the semi private rooms in the older area of the home, and in the private and semi private rooms in the newer area of the home. ABHR at the point of exit was within the care zone in the private rooms in the older area of the home.

Public Health Ontario (PHO), Best Practice for hand hygiene defined the point of care as the place where three elements occur together: the client/patient/resident, the health care provider and care or treatment involving client/patient/resident contact. The concept was used to locate hand hygiene products which were easily accessible to staff by being as close as possible, i.e., within arm's reach, to where client/patient/resident contact is taking place.

Failure to ensure ABHR is accessible at the point of care increased the risk of transmission of infectious agents.

Sources: Observations of resident's rooms, interviews with staffs, review of IPAC

Standard September 2023, and PHO Best Practice for Hand Hygiene dated December 19, 2023.

The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program by utilizing best practice guidelines with the placement of personal protective equipment (PPE) receptacles.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 (f) states Additional PPE requirements including appropriate selection application, removal, and disposal.

A CI was received by the Director for an outbreak. During the Initial tour of the home, the Inspector observed PPE garbage receptacles outside multiple resident rooms and a PSW leaving a resident's room without removing gloves at the door or washing their hands after removing gloves in the hallway.

The IPAC Lead confirmed PPE receptacles were located outside the room because the home was old, and there was no space in the rooms for the PPE receptacle bins. The IPAC lead indicated the expectation was for staff to doff at the door before leaving the room.

A registered nursing staff confirmed that PPE garbage receptacles had always been outside the resident room.

As per the Provincial Infectious Disease Advisory committee (PIDAC) November 2012, when the interaction for which PPE was used has ended, PPE should be removed immediately and disposed of.

Failure to implement best practice guideline for the doffing of PPE, increase the risk of spreading infectious agent and put residents at risk for infection.

Sources: Observation, interview with staff and review of PIDAC (2012).

This order must be complied with by January 31, 2025

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.