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

Original Public Report

Report Issue Date: March 24, 2023	
Inspection Number: 2023-1143-0001	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: ReachView Village, Uxbridge	
Lead Inspector Moses Neelam (762)	**Inspector Digital Signature** Moses H Neelam Digitally signed by Moses H Neelam Date: 2023.03.24 15:12:31 -04'00'
Additional Inspector(s) Elaina Tso (741750)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 15 -16, 21-22, 24 and 27, 2023 with February 17 and 23, 2023, conducted off-site.

The following intake(s) were inspected:

- Four intakes related to allegations of staff to resident abuse.
- An intake related to an incident resulting in an injury of a resident.
- An intake related to COVID-19 outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls 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 (7)

The licensee has failed to ensure the plan was provided to a resident as specified in the plan of care.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating an altercation between a resident and a Personal Support Worker (PSW). The resident's care plan indicated a specific intervention was to be used if strategies to assist the resident were not working. In the Long-Term Care Home's (LTCH) investigation notes, the PSW said that the resident had acted a certain way to which they reacted inappropriately. In separate interviews, a Registered Nurse (RN) and another PSW indicated that the staff member should have stopped what they were doing and carried out the intervention. As a result of not following the direction of the plan of care, the resident was negatively impacted.

Sources: The resident's care plan; Interviews with RN and PSWs; LTCH's internal investigation notes. [762]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with s. 19 (1) of LTCHA, 2007, and s. 24(1) of the FLTCA, 2021:

1). The licensee failed to protect a resident from physical abuse by a PSW.

O. Reg 246/22 defines “Physical Abuse” as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain

Rationale and Summary:

A CIR was submitted to the Director alleging physical abuse of a resident by PSW #117. The LTCH’s investigation notes indicated, PSW #113 heard the resident cry for help. Upon investigation, they witnessed PSW #117 physically abused the resident. Furthermore, at a separate time on the same day, the resident indicated to the Registered Practical Nurse (RPN) #114 that they were hurt by PSW #117. RN #112 indicated that PSW #117 admitted to being physically abusive towards the resident.

As a result, the resident was impacted negatively from the incident.

Sources: Resident's progress notes; LTCH's investigation notes; Interviews with PSW and RN. [762]

2). The licensee failed to protect a resident from verbal abuse by a RPN.

O.Reg 79/10, defines “verbal abuse” as:
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Rationale and Summary:

A CIR was submitted to the Director indicating alleged verbal abuse by a RPN towards a resident. The LTCH’s investigation report indicated that a RPN had been verbally inappropriate towards the resident. A PSW also witnessed the incident but was unable to stop their interaction. The resident indicated that they were scared because of the interaction. As a result of this incident, the resident was impacted negatively, and the resident was at risk for further incidents.

Sources: Resident's progress notes; LTCH's internal investigation notes; Interview with PSW [762]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to ensure that a person who has reasonable grounds to suspect verbal abuse immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary:

A CIR was submitted to the Director indicating alleged verbal abuse by a RPN towards a resident. The LTCH’s investigation report indicated that a RPN had been verbally inappropriate towards the resident. A PSW also witnessed the incident but failed to report to the LTCH’s management immediately. As per the RPN, the LTCH's process for notifying the Director involved the staff member notifying their manager of the alleged abuse, then the manager would report to the Director immediately. As a result, the Director was not immediately notified. Since the LTCH’s management team was not notified immediately, the resident was impacted negatively.

Sources: CIR; LTCH's internal investigation notes; Interview with PSW; LTCH's discipline letter. [762]

WRITTEN NOTIFICATION: Medication Management System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 114 (3) (a)

The licensee failed to ensure the medication management system's written policies were implemented in accordance with evidence-based practices.

Rationale and Summary:

A CIR was submitted to the Director involving a medication incident. The resident's medication was ordered to be administered prior to their meal. However, the RPN held their medication prior to meal and administered it after meal due to their test result. The RPN stated they were unsure of the appropriate documentation. The Director of Care (DOC) indicated that the administration of the medication should have been documented. The LTCH's policy indicated that "All medication administered...will be documented immediately after administration on the MAR/TAR or e-MAR/e-TAR using the proper codes by the administering Nurse". As a result, there was no risk to the resident.

Sources: Resident's progress notes; home's policy LTC medication management; Interviews with DOC and RPN. [762]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), IPAC Standard section 9.1 (f)

1). The licensee has failed to implement the Infection Prevention and Control (IPAC) standard issued by the Director.

In accordance with the IPAC Standard for Long-Term Care Homes, dated April 2022, section 9.1 (f) directs the licensee to ensure that Routine Practice and Additional Precautions are followed in the IPAC Program. At minimum, Additional Precautions shall include proper removal of Personal Protective Equipment (PPE).

Rationale and Summary:

The LTCH was in a COVID-19 outbreak during the inspection. There was signage at a resident's door indicating additional precautions. The inspector observed a PSW exiting a room and not performing hand hygiene after the removal of their soiled N95 respirator and donning of a surgical mask. Public Health Ontario has recommended six steps on taking off the personal protective equipment (PPE), step five was to remove mask/N95 respirator and step six was to perform hand hygiene.

The PSW stated that they did not perform hand hygiene after removal of their soiled N95 respirator. The IPAC lead stated that staff were expected to perform hand hygiene after the removal of their soiled N95 respirator.

Failure to follow the standard and protocol to perform hand hygiene increased the risk of transmission of COVID-19 to themselves, other residents, and staff.

Sources: Observations; Interviews with PSW and the IPAC lead; Public Health Ontario's recommendation on taking off PPE. [741750]

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), IPAC Standard section 10.4 (h)

2). The licensee has failed to implement the Infection Prevention and Control (IPAC) standard or protocol issued by the Director.

In accordance with the IPAC Standard for Long Term Care Homes, dated April 2022, section 10.4 (h) directs the licensee to ensure that the Hand Hygiene Program includes supporting residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary:

The LTCH was in a COVID-19 outbreak during the inspection. The inspectors observed a RPN and two PSWs providing lunch to three residents but did not assist the residents in performing hand hygiene prior to receiving their meal. The RPN and two PSWs confirmed that they did not help the residents to perform hand hygiene before their meal. The IPAC lead confirmed that it was required that staff help residents to perform hand hygiene before meals.

The residents were at risk for transmitting infection because they were not assisted by the staff to perform hand hygiene.

Sources: Observation and interview with RPN, PSWs and the IPAC Lead. [741750]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

Rationale and Summary:

A CIR was submitted to the Director about an incident that occurred to a resident on specific date. A diagnostic test was performed on the resident the day after the incident. The home received the diagnostic test result on the same day it was performed which revealed an injury and a significant change in health condition. Furthermore, the resident required hospitalization due to the injury.

The DOC confirmed that they should have informed the Director the day they received the diagnostic test result, as this indicated a significant change in the resident's health condition. However, the CIR was submitted to the Director two days later.

As a result of the late reporting, there was no risk to the resident.

Sources: CIR; resident's health records; interview with the DOC. [741750]

COMPLIANCE ORDER CO # Directive by Minister

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

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

Specifically, the licensee shall ensure the following:

1. The LTCH is to put in place a monitoring system to make sure that all the staff meet the testing requirements in the "COVID-19 guidance document for long-term care homes in Ontario" before being allowed to enter the home.

2. Document the process for the monitoring system and a record of the process for the monitoring system are to be kept in the home.

3. Create an audit tool to monitor the COVID-19 testing status of staff.

4. Conduct audits twice per day for two weeks to monitor the COVID-19 testing status of staff. Document the date and time, and the name of the person conducting each audit. Records of the audits are to be kept in the home.

Grounds

The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022. Specifically, not following the COVID-19 asymptomatic screen-testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective December 23, 2022.

Rationale and Summary

In accordance to section 8 of the Minister's Directive, COVID-19 guidance document for long-term care homes in Ontario, dated December 23, 2022, the licensee was required to ensure that prior to entering all staff should have an antigen test at least two times per week, on separate days, if they are up to date with their COVID-19 vaccines or at least three times per week if they are not up to date with the recommended COVID-19 vaccine doses.

The home's COVID-19 testing record indicated that the RPN completed the rapid antigen test (RAT) for one day. The RPN was fully vaccinated and worked two days in a specific week. The IPAC lead also confirmed the same. The home's monitoring process was as follows: every Monday, the IPAC lead would check the staff swab records including looking at the previous week's swab records of staff and compared it to their work schedule. When discrepancies were identified, the IPAC lead would communicate with the in-charge nurse by e-mail to do a further follow up. As a result, staff would enter the home without completing the required RAT. The IPAC lead provided the e-mail which indicated a list of staff who missed the RAT and entered the home to work in an identified week. The IPAC lead acknowledged the risk of potentially spreading infection to residents if staff did not conduct a RAT and did not follow proper PPE procedures.

Failing to ensure that staff were tested with a RAT prior to entering the home, places all residents and other staff at high risk of transmitting the COVID-19 infection especially when the home was in COVID-19 outbreak.

Sources: The COVID-19 Guidance Document for Long-Term Care Homes in Ontario; staff schedule; staff vaccination records; PANBIO Tracking Tool; Interview with the IPAC lead. [741750]

This order must be complied with by March 31, 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.