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 22, 2024

Inspection Number: 2024-1143-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: ReachView Village, Uxbridge

Lead Inspector	**Inspector Digital Signature**
Maria Paola Pistritto (741736)	Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2024.03.27 10:09:26 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-9, 2024

The following intake(s) were inspected:

- One complaint related to an unwanted resident entering their room and food concerns
- One intake related to a fall with injury.
- One intake related to a COVID-19 outbreak.

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

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
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 (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

Non-compliance with: FLTCA 2021, s. 6 (10) (b)

The licensee has failed to ensure that the resident's plan of care was revised when their care needs changed.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for a fall with injury. The resident's care plan identified a specific alarm to be in place when they were in their assistive device. Personal Support Worker (PSW) #110 transferred the resident and forgot to transfer the alarm. Falls Lead #105, PSW #112 and the Director of Care (DOC) confirmed when transferring a person with an alarm, the alarm is to be

transferred as well. During this time, the resident self-transferred from the lounge chair resulting in a fall.

The resident's care plan identified a specific alarm was being used and on observation a different alarm was being utilized. The resident's care plan indicated a specific-person transfer. Upon return from hospital, the resident was changed to a different person transfer. Both the alarm and transfer status were not reflected in the plan of care.

Failure to update the resident's plan of care when their needs changed put them at risk for injury.

Sources: Observations, resident's plan of care and interview with staff. [741736]

COMPLIANCE ORDER CO # 001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 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)]:
Specifically, the licensee shall, at a minimum:
1) IPAC Lead or Management designate is to educate Registered Nursing, PSW, PT and PTA staff regarding the appropriate selection and donning and doffing of PPE. This education will include but not limited to scenario-based return demonstrations

and audits. Randomized audits will be completed over a 4-week period on all shifts.
2) IPAC Lead or Management designate to educate RPN student #106 about the four moments of hand hygiene. This education will include but not limited to a scenario-based return demonstration of the four moments of hand hygiene. Audits to be completed for 2 weeks during RPN student #106 shift at random times.
3) Documentation of education, scenario-based return demonstrations and audits must include:

- what education was provided
- who provided the education
- name of staff educated
- date education provided
- outcome of return demonstrations and audits

This documentation is to be provided immediately to the inspector as requested.

Grounds

1) Non-compliance with: O. Reg. 246/22 s.102 (2) (b), IPAC Standard, section 9.1 (f)

The licensee has failed to implement the appropriate selection of PPE when providing direct resident care on additional precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, updated September 2023, section 9.1 (f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

Rationale and Summary

A CIR was submitted to the Director for a COVID-19 outbreak. Inspector #741736 observed Registered Practical Nurse (RPN) # 105 enter the resident's room which was on contact precautions. RPN # 105 practiced hand hygiene with a surgical mask on and entered the resident's room.

PSW #104 entered the resident's room to get them up for lunch. PSW practiced hand hygiene and put on gloves and proceeded into the resident's room without a gown. PSW #104 stated that they did not require the gown because they are not providing peri care. PSW #103 entered the room with a mask and put on gloves to assist PSW#104 without the required gown.

Inspector #741736 observed Physiotherapist (PT) #107 and Physiotherapist Assistant (PTA) #108 assisting the resident out of bed using a lift. PT #107 and PTA # 108 were not wearing gloves or gown during the interaction.

The resident's care plan indicated that staff are to follow PPE instructions from the signage put on the door and that when entering the resident's environment or have direct contact that gloves are required. Signage posted on the resident room door required a surgical mask, gown, and gloves to enter the room. RPN #105 and the IPAC Lead confirmed the home's expectation for staff to wear a mask, gown, and gloves at a minimum when entering the resident's room.

Failure of staff in selecting the appropriate PPE when providing care for residents on additional precautions, increases the risk of transmission of infectious agents.

Sources: Observations and interviews with staff. [741736]

2) Non-compliance with: O. Reg. 246/22 s.102 (2) (b), IPAC Standard, section 9.1 (b)

The licensee has failed to ensure that routine practices are followed in the IPAC program specifically with the four moments of hand hygiene.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, updated September 2023, section 9.1(b) states at minimum routine practices include hand hygiene, including but not limited to the four moments of hand hygiene.

Rationale and Summary

A CIR was submitted to the Director for a COVID-19 outbreak. Inspector #741736 observed RPN student #106 exiting a resident room without performing hand hygiene. When approached by the inspector, RPN Student #106 said they were nervous working with the RPN and just a student. The IPAC Lead confirmed the homes expectation with the four moments of hand hygiene and that RPN student was to perform hand hygiene before exiting the resident's room.

Failure to practice hand hygiene at the prescribed four moments, puts residents at risk of transmission of infectious agents.

Sources: Observations and interviews with staff.

This order must be complied with by April 19, 2024

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

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

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:

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

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.