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: March 6, 2025

Inspection Number: 2025-1143-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: ReachView Village, Uxbridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 28, 2025 and March 3, 4, 5, 2025.

The following intake(s) were inspected:

- One complaint intake related to plan of care, missing items, neglect, safety, skin and wound, no response from home to address concerns and medication management,
- One complaint intake related to an allegation of resident to resident sexual abuse, and
- One Critical Incident Report (CIR) related to an allegation of resident to resident sexual abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

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 the medication administration was not signed, for an identified resident.

The home received a written complaint regarding the uncertainty of medication administration for a resident.

The Director of Care (DOC) confirmed that the administration of the medication had not been signed for on the identified date.

Sources: Record review of Electronic Medication Administration record (eMAR), and interviews with the Complainant and Director of Care. [647]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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

The licensee had failed to ensure that an identified resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time

when the resident's care needs changed or care set out in the plan was no longer necessary.

The home received a written complaint regarding an incident of alleged abuse between two resident. Subsequently, the Director received a Critical Incident Report regarding the same incident.

The plan of care for the identified resident was not revised after the allegation of abuse whereby, an identified resident entered the room of another resident and was physically inappropriate. The current interventions that the home had put in place to prevent reoccurrence were not added to the plan of care.

The DOC and the Behavior Support Outreach (BSO) lead indicated that the plan of care should have been revised with the incident and current interventions for the identified resident.

Sources: Record review of clinical chart for both residents, Critical Incident Report, and interviews with the Complainant, both identified resident, BSO lead and Director of Care. [647]

WRITTEN NOTIFICATION: Windows

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee had failed to ensure that a window in a resident room opened to the outdoors and was accessible to the resident, had a screen and could not be opened

more than 15 centimetres.

During a complaint inspection related to air temperatures it was observed that the window in a resident room was sealed closed with plastic and duct tape.

The Executive Director (ED) indicated that there was an identified draft coming through the window as it was an old building.

Sources: Observations, interviews with the Complainant, Executive Director, and Environmental Services Manager. [647]

WRITTEN NOTIFICATION: Complaints - reporting certain matters to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 111 (1)
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The licensee had failed to ensure that a written complaint, with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The home received a written complaint regarding multiple care concerns for an identified resident and did not forward it to the Director.

The ED indicated that the written complaint was not forwarded to the Director as required.

Sources: Record review of complaint log, and interviews with the Complainant and Executive Director. [647]

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