Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 12, 2021	2021_892762_0003	006930-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Eagle Terrace
329 Eagle Street Newmarket ON L3Y 1K3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 5-8, 2021

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Log/ CIS related to an incident that lead to an injury for which the resident was taken to the hospital
- A2 infection control checklist

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Environmental Service Manager (ESM), Infection Control Manager (ICM), Staff Educator, Rai Coordinator, Registered Practical Nurses (RPN) and Personal Support Workers (PSW)

During the course of the inspection, the inspector reviewed records, conducted observations and interviewed multiple different staff.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care resident #001 that sets out the planned care.

A critical incident report was submitted to the director, related to an incident where resident #001 sustained an injury for which they had to be sent to the hospital. During the initial tour of the facility, inspector #762 conducted observations in resident #001’s room and noted that the resident had an intervention. In separate interviews, RPN #106 and PSW #105, indicated that the resident required the intervention as they were at high risk for the incident and that this was the planned care for the resident. In a separate interview Staff Educator #109 indicated that this intervention would be required to be in the care plan. Upon review, this intervention was not present until after inspector #762 had notified DOC #101. As a result, there was a risk of the staff removing the intervention as it was not in the written plan of care, when the resident required it.

Sources: Observations; record reviews; Interviews with RPN #106, PSW #105 and Staff Educator #109 [s. 6. (1) (a)]

Issued on this 18th day of October, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.