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

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Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022-1060_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Revera Long Term Care Inc.

Long-Term Care Home and City
Eagle Terrace, Newmarket

Lead Inspector
Asal Fouladgar (751)

Additional Inspector(s)
Ana Best (741722)

Inspector Digital Signature
Digitally signed by Asal Fouladgar
Date: 2022.09.19 13:07:11 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 7, 8, 2022

The following intake(s) were inspected:

- An intake related to COVID-19 outbreak
- A complaint intake related to an admission refusal

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

- Admission, Absences & Discharge
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard issued by the Director was followed.

Rationale and Summary:

The IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 10.1, stated that the licensee shall ensure the hand hygiene program includes access to hand hygiene agents including 70-90 percent (%) Alcohol-Based Hand Rub (ABHR). In addition, the IPAC Standard under section 10.4 (h), stated that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks.

During the inspection, Inspectors #751 and #741722, observed staff placed a couple of wipes on each resident's tables prior to mealtime. Personal Support Worker (PSW) #102 showed the inspectors a package of Prevail wipes which were alcohol-free and fragrance-free. PSW #102 also showed a drawer in the designated dining room which contained two packages of Huggies baby wipes. PSWs #102 and #103 stated that the home was using the above-mentioned wipes to provide hand hygiene to the residents prior and after meals.

The IPAC Manager confirmed that the home was using those wipes for the purpose of providing hand hygiene to the residents before and after meals, and snacks. Furthermore, the IPAC Manager indicated that the home had consulted with Revera's corporate office, and they had approved the home to use those alcohol-free wipes.

Failure to provide hand hygiene to the residents with 70-90% alcohol-based hand rubs, increased the risk of spreading infectious agents.

Sources: Observations, interviews with PSWs #102 and #103, and the home's IPAC Manager.

[741722]

WRITTEN NOTIFICATION [HOME TO BE SAFE, SECURE ENVIRONMENT]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 5

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

During the inspection, Inspectors #751 and #741722 observed a visitor not wearing a specific required Personal Protective Equipment (PPE) while visiting their loved one. The signage on the resident's door room indicated that they were under additional precaution and anyone entering the room was required to wear the required PPEs.

The visitor stated that they were aware of the required PPE, then proceeded to apply the missing PPE once guidance was provided by the inspectors.

The IPAC Manager stated that a staff member had demonstrated to the visitor regarding the appropriate donning and doffing of PPE the day prior and that the IPAC Manager, themselves were going to provide more education to the visitor the following day. The IPAC Manager acknowledged that the visitor was required to don the required PPE as per the home's IPAC protocol.

Failure to comply with application of the required PPE, increased the risk of residents and staff becoming ill with an infectious agent.

Sources: Observations, interviews with visitor #109 and the IPAC Manager.

[751]