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
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Original Public Report

Report Issue Date: April 28, 2023	
Inspection Number: 2023-1060-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Eagle Terrace, Newmarket	
Lead Inspector Marian Keith (741757)	**Inspector Digital Signature** Marian P Keith Digitally signed by Marian P Keith Date: 2023.05.09 08:10:47 -04'00'
Additional Inspector(s) Asal Fouladgar (751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 5, 6, 12, 13, 14, 18, 19, 2023
The inspection occurred offsite on the following date(s): April 11, 17, 2023

The following intake(s) were inspected:

- Intakes related to falls
- Intakes related to resident care and support services
- Intake related to prevention of abuse and neglect
- Intake related to nutrition and hydration

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management

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)

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

Rationale and Summary

The Ministry of Long-term Care (MLTC) received a complaint related to a resident's nutritional care.

A resident's clinical records indicated that on a specific date, changes were identified where they required staff intervention for nutritional intake. Their clinical records also indicated they had medical conditions that, along with these changes, contributed to their risk for nutrition and hydration. This new information was not reflected in the resident's written plan of care.

Registered Practical Nurse (RPN) #110, Nutrition Manager (NM) and Director of Care (DOC) indicated that the resident's changes should have been added to the written plan of care. Each person interviewed did not provide clarity for staff that should have made the changes to the care plan.

Inconsistency with staff knowledge of responsibility for documentation resulted in a failure to revise a resident's plan of care and may have put resident at risk by not communicating to other staff/disciplines their new nutritional needs and the corresponding interventions required to ensure resident's adequate intake.

Sources: resident's clinical records, interviews with an RPN #110, NM and DOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (4) (b)

The licensee failed to ensure that a resident was assessed by the Registered Dietitian (RD) for risks relating to nutrition and hydration.

Rationale and Summary

The MLTC received a complaint relating to a resident's nutritional care.

A resident's clinical records indicated that on a specific date, changes were identified where they required staff intervention for nutritional intake. Their clinical records also indicated they had medical conditions that, along with these changes, contributed to their risk for nutrition and hydration.

The home's expectation was for staff to refer to the RD of any significant changes in the resident's nutritional status. There was no referral made to the RD for assessment in the resident's clinical records.

The NM acknowledged that the identified changes to the resident's nutritional needs could have impacted overall intake. They further acknowledged that if their intake could have been impacted, that it would have been appropriate to refer them to the RD.

RPN #110 acknowledged that the identified changes to a resident's nutritional needs would be considered a nutritional risk.

The RD acknowledged that the identified changes to a resident's nutritional needs would prompt a referral to them.

The failure of the staff to ensure resident was assessed by the RD may have put them at risk for nutrition and hydration.

Sources: resident's clinical records, interviews with RPN #110, NM and RD, home's policy.

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WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

1.The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with relating to an investigation of an allegation of staff to resident abuse.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the MLTC related to an allegation of staff to resident abuse.

The home's expectation was for the Executive Director (ED) or designate to obtain written statements from the accused and any witnesses and that witness statements and interviews should be dated, timed and signed and these statements and documents were to be kept in the home's investigative file.

The DOC and ED confirmed they had interviewed multiple staff related to this CIR, however, they did not have their signed written statements or details of the interviews in the investigation file.

Failure to document and retain investigative notes may have put the resident at risk by not procuring necessary evidence to support the resident in the process of investigation of all allegations of abuse.

Sources: CIR, the home's investigation notes, interviews with DOC and ED, home's policy.

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2.The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with when an RPN #102 did not immediately report an allegation of staff to resident abuse.

Rationale and Summary

A complaint was made to the MLTC related to an allegation of staff to resident abuse.

A review of the resident's clinical records indicated the documentation of an identified allegation of staff to resident abuse on a specific date, but it was not reported to the home's management team.

RPN #102 indicated that they were required to report an allegation of staff to resident abuse immediately to the home's DOC or a person in charge (for example, a manager on-call).

The ED confirmed the home's management team was not notified regarding the allegation of abuse and RPN #102 should have reported this immediately so it could be investigated.

There was risk to the safety and well-being of the resident when this allegation of staff to resident abuse was not reported and investigated immediately.

Sources: CIR, resident's clinical records, interviews with ED, RPN #102 and other staff.

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