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: November 29, 2023	
Inspection Number: 2023-1060-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Eagle Terrace, Newmarket	
Lead Inspector Nicole Lemieux (721709)	**Inspector Digital Signature**
Additional Inspector(s) Rodolfo Ramon (704757)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 7 to 10, and 14 to 17, 2023

The following intake(s) were inspected:

- One intake related to a Proactive Compliance Inspection (PCI).

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Pain Management

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

O. Reg. 246/22, s. 96 (2) (d)

The licensee has failed to ensure that procedures were implemented to ensure that all plumbing fixtures were maintained, free of cracks.

Rationale and Summary

While conducting a PCI, it was noted that a leak under the sink in a resident's room was brought to the home's attention during a Resident's Council meeting. The same day, an electronic maintenance care request was submitted requesting to repair the sink. A review of the home's leadership meeting minutes and the electronic maintenance care records stated the sink was repaired.

During the Inspector's observations, a receptacle was observed under the sink in the bathroom of the room collecting debris. The resident in the room informed the Inspector that the sink was not fixed.

The Executive Director (ED) informed the Inspector that Environmental Services Manager (ESM) #114 had reported during the leadership meeting previously, that the leak was repaired and was unaware that the sink continued to leak.

During the inspection, ESM #117 confirmed with the Inspector that the sink was repaired.

Sources: Maintenance care electronic records, leadership meeting minutes, Resident's Council meeting minutes, observations, interviews with the ESM #117 and the ED. [704757]

Date Remedy Implemented: November 16, 2023.

WRITTEN NOTIFICATION: DUTY TO RESPOND

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

Non-compliance with: FLTCA, 2021, s. 63 (3)

The licensee has failed to ensure that when the Resident's Council advised the home of a recommendation, a response was provided to the council in writing, within 10 days of receiving the advice.

Rationale and Summary

While conducting a PCI, it was noted that the Resident's Council made a recommendation to the home to repair a leak under the bathroom sink of a resident's room. The resident informed the Inspector that the sink was not repaired, and no written response was provided to the Resident's Council. The Recreation Manager and the ED confirmed no response was provided to the council.

Not providing a written response resulted in a delay in implementation of the recommendation made by the Resident's Council.

Sources: Resident's Council meeting minutes, interviews with a resident, the Recreation Manager, and the ED. [704757]

WRITTEN NOTIFICATION: CONTINENCE CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that the plan to promote and manage bowel and bladder continence was implemented for a resident.

Rationale and Summary

Review of a resident's plan of care indicated that the resident was incontinent and required assistance for incontinence care. According to the resident's plan of care, they were required to have a device within reach as per part of their plan of care.

During observations, the device was observed to be not within reach of the resident. A Registered Practical Nurse (RPN) confirmed that the resident required to have the device within reach.

Failing to ensure the device was within reach placed the resident at risk of not having their needs met.

Sources: A resident's clinical records, observations, interview with an RPN. [704757]