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

Original Public Report

Report Issue Date: July 25, 2024	
Inspection Number: 2024-1060-0003	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Eagle Terrace, Newmarket	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26 to 28, 2024 and July 2 to 4, 10 to 12, and 15, 2024.

The following intake(s) were inspected:

- One intake related to resident-to-resident physical abuse.
- One intake related to a complaint related to concerns of neglect and pain management.
- Intake: #00117776 – First Follow-up to Compliance order #005 from Inspection #2024_1060_0002 - O. Reg. 246/22, s.356 (3) 1, with a Compliance Due Date (CDD) May 29, 2024

- Intake: #00117772 – First Follow-up to Compliance Order #002 from Inspection #2024_1060_0002 - O. Reg. 246/22, s. 93 (2)(c), with a CDD May 29, 2024
- Intake: #00117771 – First Follow-up to Compliance Order #001 from Inspection #2024_1060_0002 - FLTCA, 2021, s.184 (3), with a CDD May 29, 2024
- Intake: #00117774 - First Follow-up to Compliance Order #003 from Inspection #2024_1060_0002 - O. Reg. 246/22, s. 102(2) (b), with a CDD May 29, 2024
- Intake: #00117884 – First Follow-up to Compliance Order #004 from Inspection #2024_1060_0002 - O. Reg. 246/22, s. 102(5), with a CDD April 30, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #005 from Inspection #2024-1060-0002 related to O. Reg. 246/22, s. 356 (3) 1

Order #002 from Inspection #2024-1060-0002 related to O. Reg. 246/22, s. 93 (2) (c)

Order #001 from Inspection #2024-1060-0002 related to FLTCA, 2021, s. 184 (3)

Order #003 from Inspection #2024-1060-0002 related to O. Reg. 246/22, s. 102 (2) (b)

Order #004 from Inspection #2024-1060-0002 related to O. Reg. 246/22, s. 102 (5)

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (9) (a)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection of a resident were monitored in accordance with any standard or protocol issued by the Director.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, updated September 2023, section 3.1 (b) states that the licensee shall ensure that surveillance is performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary

A complaint was made to the Director related to alleged abuse and neglect regarding a resident. The resident was verbalizing signs and symptoms of an infection on multiple occasions. Progress notes confirmed that the resident was not monitored for signs and symptoms of infection on either occasion or while waiting for results. A Registered Nurse (RN) and the Executive Director (ED) confirmed that monitoring for signs and symptoms of infection would be documented in the resident's clinical records every shift until the symptoms had resolved. The ED further confirmed that this was not completed as per the home's process or expectations upon review of the resident's clinical records.

Failing to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored increases the risk of worsening condition for the resident.

Sources: Resident's clinical records, interview with an RN and the ED.

WRITTEN NOTIFICATION: RECORDS OF CURRENT RESIDENTS

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

Non-compliance with: O. Reg. 246/22, s. 275

Records of current residents

s. 275. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home.

The licensee has failed to ensure that the records of the residents of the home were kept at the home, specifically the physician's rounds list.

Rationale and Summary

A complaint was made to the Director related to alleged abuse and neglect regarding a resident. Upon request by the Inspector, the home was unable to provide the physician's rounds resident list records or forms. Discussion with an RN and the ED identified that this record was not kept in the home as it was destroyed following the physician's visit in the home. The ED and the physician confirmed that

the physician's rounds list was a resident's health record and should be kept in the home for retention of health records.

Failing to keep resident records in the home puts the residents at risk for not having access to accurate medical history.

Sources: Interviews with an RN, the physician and the ED.