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

Public Report

Report Issue Date: December 19, 2024

Inspection Number: 2024-1060-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Eagle Terrace, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 13-15 and 18-22, 2024

The following intake(s) were inspected:
·An intake related to improper care of a resident by staff
·An intake related to the improper/incompetent care of a resident's wound
·An intake related to call bell access and safety for a resident
·An intake related to a fall of a resident resulting in injury

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's right to privacy during the provision of care was supported.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint with regards to a resident not being afforded privacy in their room due to the ongoing presence of a visitor of the resident's co-resident.

On numerous occasions, the Inspector observed the visitor to be present in the shared room, including during overnight resting hours. During an interview with the family visitor, they identified that they are generally in the resident's room with the exception of short breaks and they had been provided with comfort items by the long-term care home (LTCH) to facilitate their sleeping in the resident's room.

During an interview with a Personal Support Worker (PSW), they indicated that the expectation is that the visitor is to exit the room during the provision of care to the resident regardless of time of day. The PSW also indicated that the door is to remain open at all times while the visitor is present in the room with the resident for safety

reasons. During an interview with a registered staff member, they reported that the visitor will often remain in the room when care is provided overnight to the resident. In discussion with the Executive Director (ED) it was reported that in their view, privacy was a challenge, but the visitor was permitted to be present in the room to provide support to their loved one.

Failure to ensure that an individual visiting the co-resident of the resident exited the shared accommodation room during the provision of care infringed on the resident's right to privacy.

Sources: interviews with staff, interview with visitor, observations.

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from neglect by staff on a specified date.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rational and Summary
A Critical Incident Report (CIR) was submitted to the Director regarding receipt of a

written complaint concerning the care of a resident. A subsequent CIR was submitted to the Director related to incompetent/improper treatment resulting in harm or risk to a resident.

The resident's health records indicated that the resident was at risk of impaired skin integrity. Altered skin integrity was identified for the resident on a specific date.

The resident's health records provided instructions for the treatment of the identified altered skin integrity and demonstrated that the treatment had been administered as per the instructions for a specified time period.

Health records for the resident on a specific date, detailed that there were concerns identified with the resident's altered skin integrity and that the altered skin integrity was worsening.

An internal investigation was initiated by the home's Executive Director (ED). The internal investigation confirmed, through an interview, that the Registered Nurse (RN) working on a specified date, had documented that they had completed the treatment for the altered skin integrity as per the instructions, however, the treatment had not been completed. The internal investigation report substantiated the outcome of the home's internal investigation as abuse/neglect. The ED confirmed the findings of the investigation in an interview.

Failure to complete the treatment for the resident's altered skin integrity, as per the treatment ordered, placed the resident at increased risk of infection and other negative clinical outcomes.

Sources: Resident's health records, LTCH's Internal Investigation Report, interview with the ED.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident's identified altered skin integrity was reassessed at minimum, weekly.

Rationale and Summary
A CIR was submitted to the Director related to incompetent/improper treatment resulting in harm to a resident.

Health records for the resident indicated that the altered skin integrity was first identified on a specific date.

Review of Skin and Wound Evaluations completed for the resident in relation to the identified altered skin integrity indicated that the re-assessments were not completed on a weekly basis during a specified time period.

RN #111 confirmed that the required skin and wound assessments for the resident were not completed on a weekly basis during the specified time period and should have been.

Failure to complete, at minimum, weekly skin and wound assessments of the

resident's identified altered skin integrity, placed the resident at increased risk of changes in the altered skin integrity being undetected, including the presence of infection.

Sources: Health records for a resident, Skin and Wound Evaluations, interview with RN #111.

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (5)
Food production
s. 78 (5) If any food or beverages are prepared in the long-term care home for persons who are not residents of the home, the licensee shall maintain, and keep for at least seven years, records that specify for each week,
(a) the number of meals prepared for persons who are not residents of the home; and
(b) the revenue and internal recoveries made by the licensee relating to the sale or provision of any food and beverage prepared in the home, including revenue and internal recoveries made from cafeteria sales and catering. O. Reg. 246/22, s. 78 (5).

The Licensee has failed to ensure that costs associated with any prepared food items served to non-residents are recovered and records of the recovered expenses are maintained.

Rationale and Summary
During an interview with the family member of a resident of the LTCH, the family member reported that the LTCH provides them with a dinner meal on a daily basis.

Dietary Aide (DA) #113 indicated that food production is based on calculated meal

counts, although there is always a small margin for additional meals to meet resident's needs. The DA indicated that some meal items that have not been served can be saved and utilized for resident meals the next day, while some items must be disposed of for food safety reasons.

During an interview with the ED, it was reported that the home did not prepare specific meals for family members, but if there were food items that are left over from a meal service that would otherwise be disposed of, they may be offered to a family member. The ED also reported that it was a regular practice of the home to provide food to family members and visitors during the snack pass. The ED indicated that any food items that were served at snack or meals would be funded through the raw food budget for residents and indicated that there was no process in place for financial recovery of the costs associated with the food items being provided to non-residents.

Failure to recover costs of food items served to non-residents created a risk of reduced availability of financial and food resources for residents of the LTCH.

Sources: interviews with family member, DA #113, and ED.

WRITTEN NOTIFICATION: VISITOR POLICY

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (2)
Visitor policy
s. 267 (2) Every licensee of a long-term care home shall maintain visitor logs for a minimum of 30 days which include, at a minimum,
(a) the name and contact information of the visitor;
(b) the time and date of the visit; and
(c) the name of the resident visited.

Rationale and Summary

During routine observations of a resident home area (RHA) staff #105 and #107 reported concerns that a family member was residing in a resident's room and had been for many months.

During an interview, the ED reported that the family member was not residing in the LTCH but rather was an essential caregiver and as such was permitted to remain in the home for extended periods of time. The ED confirmed that as an essential caregiver, the expectation is that individuals are signing in and out of the LTCH. However upon review of the Visitor Logs for a specified time frame there was no record of the family member signing in or out of the LTCH. According to the Visitor's Procedure, provided by the ED, the expectation is that all visitors to the home are to sign in and out utilizing the digital visitor sign in tool to ensure the most accurate reporting for staff in the event of an emergency.

Failure to ensure that visitors are utilizing the digital visitor sign in tool creates a reduced opportunity for contact tracing in the event of an outbreak as well as an increased risk to resident safety if unknown or unaccounted for individuals have entered the LTCH.

Sources: observations, LTCH visitor logs, LTCH's Visitor's Procedure, interviews with staff #105, #107 and the ED.