Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 5, 2019	2019_654618_0001	005697-17, 007564-17, 003793-18, 028571-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Main Street Terrace
77 Main Street TORONTO ON M4E 2V6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 22, 23, 24, 25, 28, 29, 30, 2019.

The following Critical Incident intakes were inspected during this inspection:
Log #028571-18, Critical Incident Report (CIR) #2589-000010-18, related to falls.
Log #005697-17, CIR #2589-000010-17, related to responsive behaviours.
Log #007564-17, CIR # 2589-000004-17, related to responsive behaviours and reporting.
Log #003793-18, CIR# 2589-000001-18, related to hospitalization and change in condition.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Practical Nurse (RPN), and Personal Support Worker (PSW).

During the course of the inspection, the inspector observed resident care, observed staff to resident interaction, reviewed resident health records and review the homes investigation file.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The Licensee has failed to ensure that the Director was informed when an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, but the licensee was unable to determine whether the injury had resulted in a significant change to in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under section (4).

Review of Critical Incident Report (CIR) # 2589-000004-17, revealed that on an identified date in 2017, resident #001 incurred a fall which resulted in an identified injury.

On the same date identified above, the home received information from the hospital confirming the resident's identified injury.

The home submitted the CIR to the Director six days after being made aware of the resident's change in condition.

Interview with ADOC, confirmed that the home had been made aware of the resident's change in condition on an identified date in 2017, and that the CIR should have been submitted sooner.

The ADOC was not able to explain the circumstances which delayed the submission of the CIR.

Issued on this 5th day of February, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.