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

Toronto District
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: July 27, 2023	
Inspection Number: 2023-1103-0002	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Main Street Terrace, Toronto	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2023.08.14 17:04:30 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 4, 5, 6, 2023
The inspection occurred offsite on the following date(s): July 27, 2023

The following intake(s) were inspected:
Intake: #00022496 (CI: #M2589-000007-23) was related to falls.

The following intakes were completed in this inspection: Intake #00022711 (CI: #M2589-000008-23), and Intake #00088530 (CI #M2589-000011-23) were related to falls with injury.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Reporting and Complaints
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 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary
A resident's health care records indicated that they were at risk for falls with interventions in place which required staff's assistance.

A PSW was supervising the resident back to their room when another resident asked for help. The PSW left the resident unattended while they went and assisted someone else. As a result, the resident experienced a fall causing an injury that resulted in a significant change in their health status, for which the resident was taken to a trauma center.

The PSW acknowledged that the resident was at risk for falls and should not have been left unattended and that they should have stayed with the resident.

The DOC told the inspector that the staff were expected to follow resident's care plans.

Sources: Critical Incident Report (CIR) # 2589-000007-23, resident health records, interview with the DOC others.
[698]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident that caused an injury to resident #001, for which the resident was taken to trauma center, which resulted in a significant change in the resident's health status.

In accordance with O. Reg 246/22 s. 115 (4) (b), it states that 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, where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine 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 (5).

Rationale and Summary
The home submitted a CI report related to an incident that occurred in the home.

A resident experienced a fall which resulted in a significant change in the resident's health status, for which the resident was taken to a trauma center.

The CIR was submitted days later, more than one business day after the occurrence of the incident that caused an injury to the resident.

The Administrator acknowledged that the CI was not submitted within the required timeframes as required under the legislation.

Sources: Critical Incident Report (CIR) # 2589-000007-23, resident's health records, and interview with the Administrator.