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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Original Public Report

Report Issue Date: December 7, 2023.

Inspection Number: 2023-1103-0003

Inspection Type:
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Main Street Terrace, Toronto

Lead Inspector	**Inspector Digital Signature**
Trudy Rojas-Silva (000759)	Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2023.12.12 16:16:48 -05'00'

Additional Inspector(s)
Cindy Cao (000757)

Training Specialist, Iana Mologuina (763) attended this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27-30, 2023.

The following intake(s) were inspected:

- Critical Incident (CI) Intakes: #00091098/ CI#2589-000015-23 and #00094271/ CI#2589-000018-23 are related to fall prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty Of Licensee To Comply With Plan Of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure the care set out in the plan of care is provided to the resident, as specified in the plan of care.

Rationale and Summary

A resident had an unwitnessed fall and sustained an injury.

A review of the resident's plan of care indicated the resident had an intervention in place to manage their risk for falls.

The staff member confirmed that they did not follow this intervention and as a

result, the resident sustained a fall.

The Director of Nursing (DON) verified the staff member did not follow the resident's plan of care, and as a result, they fell and sustained an injury.

The staff failed to follow the plan of care which put the resident at risk for fall and injury.

Sources: Interview with DON and other relevant staff, resident clinical records. [000759]

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that Head Injury Routine (HIR) monitoring was completed for the resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with. Specifically, registered nursing staff did not comply with the home's Post-Fall Management Policy to conduct HIR monitoring for a specified period of time.

Rationale and Summary

The resident sustained an unwitnessed fall which resulted in an injury.

The home's policy directs staff to initiate HIR for a specific period of time, when a resident sustains an unwitnessed fall.

The resident clinical records indicated the HIR was not continued for the specified duration.

The DON acknowledged the HIR should have continued for the resident for the specified time as per the home's policy.

Failure to continue the HIR put the resident at risk of unidentified injury.

Sources: Resident clinical records, the home's Policy, interviews with DOC and other relevant staff.
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