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: Monday, January 22, 2024	
Inspection Number: 2023-1103-0004	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Main Street Terrace, Toronto	
Lead Inspector Michael Chan (000708)	**Inspector Digital Signature** Michael K Chan Digitally signed by Michael K Chan Date: 2024.01.29 14:11:01 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3-5, 8-10, 2024

The following intake(s) were inspected:

- Intake: #00096801 [Critical Incident (CI):2589-000022-23], Intake: #00104665 [CI: 2589-000033-23] - Related to Infection Prevention and Control (IPAC)
- Intake: #00100321 [CI: 2589-000025-23] - Related to improper care of a resident

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

Resident Care and Support Services
Infection Prevention and Control

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 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for one resident.

Rational and Summary

A resident's plan of care indicated that they were to receive an intervention every month. Staff and management at the home stated that documentation for intervention is completed in the progress notes and in Point of Care (POC).

A staff confirmed that in intervention was provided in a specified month. However, they stated it was not documented and could not provide the documentation of the care provided. Review of the resident's clinical record did not indicate that the resident received the intervention.

Failure of the home to document the provision of care can lead to the inability of the home to monitor the care the resident was receiving.

Source: Interview with the home's staff and management, review of the resident's clinical record.

[000708]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act using the Critical Incident Report (CIR) system.

Rational and Summary

The home was declared in a confirmed disease outbreak on a specified date. A CIR

was submitted to the Director related to the confirmed outbreak on the next day. The confirmed outbreak was not reported to the Director immediately through the after-hours reporting system and was reported the next day. The home was aware that the confirmed outbreak was required to be reported immediately to the Ministry and confirmed that the Director was not notified immediately.

Failure of the home to immediately inform the Director can lead to the inability of the Ministry to monitor the outbreak status in the home.

Source: Critical Incident Report, interview with the home's management, email correspondence from the home.