Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 15, 2023	
Inspection Number: 2024-1103-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Main Street Terrace, Toronto	
Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2, 3, 6, 7, 8, 2024

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00107689 - CI #2589-000003-24 - was related to falls prevention and management.
- Intake: #00108101 - CI #2589-000004-24 - was related to a disease outbreak

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement the IPAC Standard issued by the Director with respect to donning and doffing of personal protective equipment (PPE).

The home failed to ensure additional precautions, as part of the IPAC program, were in place in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).
Specifically, the licensee did not ensure that a PSW applied the necessary PPE when attending to a resident who was on additional precautions.

Rational and Summary
During observations on a Resident Home Area (RHA), signage on a resident's room indicated they were on additional precautions. A Personal Support Worker (PSW) entered the resident's room without donning and doffing the required PPE.

The staff member confirmed they did not don or doff the required PPE and left the room wearing the same mask. The IPAC Manager confirmed that staff were expected to wear the required PPE by donning and doffing when entering or exiting

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a resident's room that indicated additional precautions.

Failure to ensure that staff wear the correct PPE in accordance with routine practices and additional precautions could lead to the spread of infections.

Sources: Observations, interviews with PSW and IPAC Manager.
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