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

Public Report

Report Issue Date: April 10, 2025
Inspection Number: 2025-1103-0002
Inspection Type: Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Main Street Terrace, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 24-28, and 31, 2025 and April 1-2, 8, and 10, 2025

The inspection occurred offsite on the following date(s): March 28, 2025

The following intake(s) were inspected:

Intake: #00138075, related to loss of essential services
Intake: #00140069, related to an unwitnessed fall of a resident

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

Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
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 (9) 1.
Plan of care
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 a staff member documented a resident's care provision. The resident's care plan indicated that they required certain care at a specific interval. Two staff members confirmed that the provision of care was not documented at the frequency required in the resident's care plan.

Sources: Resident's clinical care record, interviews with staff members and supervisors.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed. Staff stated that the resident's continence product needed to be reassessed because their continence level changed. The home's management confirmed that the care plan should have been reviewed and

revised when staff determined the resident's continence needs had changed.

Sources: The resident's clinical record, interviews with staff and supervisors.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's plan of care was implemented when staff did not provide required care at the frequency described in their care plan. The resident's care plan noted that staff were to conduct continence checks at a specified frequency. Several staff members acknowledged that they did not implement the resident's continence care according to the frequency written in their care plan.

Sources: The resident's clinical record, interviews with staff members and a supervisor.

WRITTEN NOTIFICATION: Emergency plans

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (2)
Emergency plans
s. 268 (2) Every licensee of a long-term care home shall ensure that the emergency

plans for the home are recorded in writing.

The licensee has failed to ensure that the long-term care home's emergency plans were recorded in writing for the loss of essential services.

Specifically, there was no written emergency plan pertaining to elevator service failures. The home had only one elevator, and there were multiple past incidents of service failure due to the age of the equipment.

Sources: Email correspondence and an interview with the home's Administrator.

COMPLIANCE ORDER CO #001 Accommodation services

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (c) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

1) A written plan and timeline for enhanced preventative maintenance inspections and the modernization of elevator components developed in consultation with your preferred elevator service provider(s) and/or independent elevator consultant(s).
2) This plan shall ensure that inspections are more comprehensive than prior routine checks and prioritize replacing aging and obsolete components with newer alternatives that deliver improved performance, increased longevity, and readily

accessible replacement parts.

The completion of this plan will deem this order as implemented and complied.

Please submit the written plan for achieving compliance with the order issued under inspection #2025-1103-0002 by July 4, 2025.

Please ensure that the submitted written plan does not contain any Personal Information (PI)/Personal Health Information (PHI).

Grounds

The licensee has failed to ensure that the home's only elevator was maintained in a safe condition and in a good state of repair.

The home's elevator experienced malfunctions, and was out-of-service on two separate occasions for a total of six days. Service calls indicated that malfunctions had resulted in trapped persons requiring extraction from the elevator on three occasions.

The home's management acknowledged that while serviceable, the elevator would remain prone to multi-day breakdowns due to age of the equipment and the difficulty in procuring replacement parts for its obsolete components. They also acknowledged that there were no active plans to modernize the elevator other than continuing with routine maintenance services.

The absence of any plan to replace or modernize the equipment poses a continued risk to the safety and well-being of residents given the home's reliance on the single elevator.

Sources: Critical Incident System (CIS) Report, elevator service provider's service

calls, and interviews with the home's management.

This order must be complied with by August 4, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.