



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_252513_0010	T-1206-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON M4E 2V6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 2, 24, and 26, 2015.

The following inspections were conducted concurrently: T-1367-14, T-1471-14, T-2237 -15, and T-2335-15.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSWs), registered staff and Director of Care (DOC).

During the course of the inspection, reviewed the resident's health record, staffing schedules/assignments, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).



Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Record review of the resident's progress notes and assessments revealed that resident #001 was ambulatory, continent and living with an identified medical diagnosis. On a specified date and time, resident #001 fell at his/her bedside while going to the bathroom and used the call bell to summon assistance. He/she complained of pain in an identified area.

Review of the "Pain Assessment and Symptom Management" policy LTC-E-80, revised August 2012, identified that if the resident complained of pain, a quick pain assessment on the resident would be completed using a quick assessment called "PQRST" and documented. Further, the resident's pain would be measured using a standardized, evidence-informed clinical tool, and the nurse would determine what tool was most appropriate for accurate pain assessment, based on the resident's cognitive, physical and behavioural characteristics.

Review of the resident's progress notes and assessments for a specified date revealed that a pain assessment was not completed immediately after the resident fell nor during the remainder of the shift.

Interview with staff #100 revealed that a pain assessment was not completed.

Interview with the Director of Care confirmed that the Pain Assessment and Symptom Management policy was not complied with, as resident #001 was not assessed for pain post fall as required. [s. 8. (1) (b)]



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Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
O. Reg. 79/10, s. 49 (2).**

Findings/Faits saillants :



1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of the progress notes and assessments revealed that resident #001 was ambulatory, continent and living with an identified medical diagnosis.

The progress notes on a specified date and time, indicated that resident #001 fell at his/her bedside while going to the bathroom and used the call bell to summon assistance.

The "Fall Intervention Risk Management (FIRM) Program," LTC-E-60, identified that upon discovering a resident who had fallen, the nurse would complete an immediate assessment of the resident and implement appropriate follow-up actions.

Interviews with staff #100 and #101 revealed that a general post fall assessment was conducted and documented in the progress notes. No injuries were found. Interview with staff #100 revealed that a clinically appropriate assessment instrument specifically designed for falls was not used.

Interview with the director of care confirmed that a falls assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.



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Issued on this 31st day of July, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.