Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2017	2017_493652_0018	026791-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 27,28,29,30, and December 1, 2017

During the course of the inspection, the inspector conducted a tour of the home; observed staff to resident interactions and the provision of care, resident to resident interactions, medication administration, infection control and prevention practices, conducted record review of the home's policy for continence care, written processes for handling of medication incidents and adverse drug reactions, residents' healthcare records.

During the course of the inspection, the inspector(s) spoke with Executive Director, associate director of care (ADOC), staff educator, RAI MDS Coordinator/ acting director of care, registered practical nurses (RPNs), registered nurses (RN), personal support services, Residents' Council president and Family Council representative, residents, substitute decision-makers (SDMs).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's care needs.

Resident #001 triggered for a Quality of Care and Quality of Life Indicator in stage one of the Resident Quality Inspection.

Record review of resident #001's identified assessment on an identified date revealed he/she has an identified diagnosis and uses a specialized appliance.

Record review of resident #001's plan of care and kardex on an identified date revealed his/her specialized appliance and identified care needs were not mentioned in the plan.

Resident #001 was observed on two identified dates with his/her specialized appliance.

Record review of an identified training presentation provided to registered staff revealed the nurse to:
-Review the Resident's relevant medical history associated with an identified diagnosis
-Complete the 24 hour Admission Assessment/Care Plan to identify level of the identified diagnosis
-Initiate 3-Day identified record for the unregulated care provider (UCP) to complete
-Complete an identified assessment in point click care (PCC)
- Determine if the Resident is a candidate for an identified care Program

Interview with PSW #100 revealed resident #001 has a specialized appliance and has an identified diagnosis. PSW #100 also revealed resident #001's specialized appliance an identified care needs were not mentioned on resident #001's identified healthcare record.

Interview with RPN #101 revealed resident #001's specialized appliance an identified care needs were not mentioned on his/her identified healthcare record.

Interview with the Acting Director of Care (ADOC) revealed resident #001's plan of care did not identify his/her specialized appliance an identified care needs. [s. 26. (3) 8.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who has an identified diagnosis received an assessment that:
-includes identification of causal factors, patterns, type and potential to restore function with specific interventions, and
-is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of an identified diagnosis where the condition or circumstances of the resident require.

Record review of resident #001's chart revealed a Resident Admission for Registered Staff form which revealed an identified assessment was not completed for him/her on an identified date.

Record review of resident #001's health care records in point click care (PCC) revealed an identified assessment was not completed since his/her admission on an identified date.

Record review of an identified training presentation provided to registered staff revealed the nurse to:
-Review the Resident's relevant medical history associated with an identified diagnosis
-Complete the 24 hour Admission Assessment/Care Plan to identify level of the identified diagnosis
-Initiate 3-Day identified record for the unregulated care provider (UCP) to complete
-Complete and identified assessment in point click care (PCC)

- Determine if the Resident is a candidate for an identified Care Program

Resident #001 was observed on two identified dates with his/her specialized appliance.

Interview with PSW #100 revealed resident #001 has a specialized appliance an identified diagnosis.

Interview with RPN #100 revealed an identified assessment has not been completed for resident #001 since his/her admission on an identified date.

Interview with the Acting Director of Care (ADOC) revealed resident #001 has a specialized appliance and did not have an identified assessment completed since his/her admission on an identified date. The ADOC also revealed the expectation is that registered staff complete a 3-Day record and an identified assessment upon admission. [s. 51. (2) (a)]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.