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

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Original Public Report

Report Issue Date: October 31, 2022	
Inspection Number: 2022-1103-0001	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Main Street Terrace, Toronto	
Lead Inspector Ivy Lam (646)	**Inspector Digital Signature**
Additional Inspector(s) Maya Kuzmin (741674) Goldie Acai (741521)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 13, 14, 17, 18, 19, 20, 21, 24, and 25, 2022.

The following intake(s) were inspected:

- Intake: #00001584-[CI: 2589-000013-21] and Intake: #00003749-[CI: 2589-000006-21] related to resident to resident abuse;
- Intake: #00003653-[CI: 2589-000007-21] related to unknown fracture;
- Intake: #00004151-[CI: 2589-000015-22] related to alleged staff to resident abuse and resident care concerns;
- Intake: #00004216-[CI: 2589-000011-22]; intake: #00004604-[CI: 2589-000012-22], and intake: #00004606-[CI: 2589-000013-22] related to falls with injury;
- Intake: #00005847-[CI: 2589-000010-21] related to medication incident; and

Intake: #00005873-[CI: 2589-000012-21] related to loss of essential services.

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

Medication Management
Housekeeping, Laundry and Maintenance Services
Falls Prevention and Management

Infection Prevention and Control
Responsive Behaviours
Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)
The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary:
A resident was at risk for falls; their most recent fall was from self-transfer. The Registered Practical Nurse (RPN) and Physiotherapist (PT) indicated that to prevent falls, the staff had a particular intervention related to the resident's tendency to self-transfer.

The intervention was not included in the written plan of care. The RPN and the Director of Care (DOC) indicated that the registered staff needed to update the care plan to include the intervention, but had not yet been done.

The resident's care plan was updated with the intervention above on October 24, 2022.

Sources: Resident's care plan, post-fall assessments; observations of resident and room environment, and interviews with Registered Practical Nurse (RPN), Physiotherapist (PT), and Director of Care (DOC). [646]

Date Remedy Implemented: October 24, 2022

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 114 (3) (a)

The licensee failed to comply with the homes medication management policy for administering of a medication as per their medication policy for a resident.

O. Reg 79/10, s. 114(3)(a) requires that the written policies and protocols developed for the medication management system to ensure accurate administration of all drugs used in the home is implemented in accordance with evidence-based practices.

The home's policy instructed registered staff to provide a treatment if a resident's diagnostic monitoring results indicated a need to address their health condition. If the resident refused the treatment, the staff were to administer a specific medication.

Rationale and Summary:
The resident had two incidents where the home's policy was not complied with. During the first incident, the resident's monitoring results indicated that a treatment would be needed. The Registered Nurse failed to the specific medication when the resident refused the treatment. The staff continued to monitor the resident without administering any treatment to manage resident's condition until their monitoring results indicated further decline. Later in the same day, an RPN administered half of the treatment than what was indicated in the policy, and called the physician (MD) for an order to administer the identified medication. The resident was sent to the hospital for further treatment post administration of their medication.

The resident was at risk of adverse outcomes when staff failed to comply with the home's policy to manage the resident's condition.

Sources: Resident's progress notes; Electronic Medication Administration Record (eMAR) orders; Assessments of incident; Medication policy and algorithm; and interviews with RPN and Registered Nurse (RN).

[741521]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (a)

The licensee has failed to implement surveillance protocols issued by the Director for a particular communicable disease or disease of public health significance with regard to proper use of COVID-19 testing kits.

Rationale and Summary:
A Personal Support Worker (PSW) was observed administering rapid antigen tests (RAT) for visitors on separate occasions, emptying the entire contents of the test tube onto the tester strip. The PSW then waited a maximum of eight minutes before reading the test results. The testing kit instructed that four drops of the sample should be dropped onto the tester strip, and the results should be read between 15 and 30 minutes of the sample resting in the tester strip.

The Infection Prevention and Control (IPAC) lead indicated that the staff did not have instructions for the RAT kits being used and were not trained on the manufacturer's directions.

There was an increased risk of transmission of infection, when staff failed to follow the RAT kit instructions.

Sources: SARS-CoV-2 Rapid Antigen Test instructions; observations; and interviews with Personal Support Worker (PSW) and the IPAC lead.
[741521]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement standards or protocols issued by the Director with respect to IPAC, specifically:

(1) The licensee failed to ensure that routine and additional precautions were implemented with respect to the IPAC program.

(a) The home failed to ensure that staff followed routine precautions in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, additional requirement 9.1 (d), which directs homes to ensure proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary:
A PSW was observed exiting two residents' shared room wearing gloves. The PSW proceeded to touch the laundry bin and throw out the garbage located outside of the room, before removing gloves and performing hand hygiene.

The PSW acknowledged that they were wearing gloves upon exiting the room and that hand hygiene should be performed post exiting the room. The RN indicated that staff were expected to remove PPE and perform hand hygiene when exiting a resident room.

There was an increased risk of infection transmission when staff did not appropriately dispose of PPE.

Sources: Infection Prevention and Control - Routine Practice and Additional Precautions Policy (IPC2-010.06); observations; and interview with PSW and RN.
[741674]

(b) The home failed to ensure that staff followed additional precautions in accordance with the IPAC Standard. Specifically, additional requirement 9.1 (f) related to additional PPE requirements, including appropriate selection, application, removal and disposal.

Rationale and Summary:
A Housekeeper did not don gown and gloves when entering a resident's room. Contact precautions were in place, which included gown and gloves as additional precautions. The staff member was unaware of the requirements for additional precautions for this resident's room.

Failure of staff to use PPE as required by additional precautions increased the risk of transmission of infectious disease.

Sources: Infection Prevention and Control Standard for Long Term Care Homes April 2022; observation; and interview with the Housekeeper.

[741521]

(2) The licensee failed to ensure that their hand hygiene program was implemented in accordance with the IPAC Standard. Specifically, support for residents to perform hand hygiene prior to receiving meals as required by additional requirement 10.4 (h) under the Standard.

Rationale and Summary:
Residents were observed entering the dining room for meals. Staff did not assist or offer residents an opportunity to perform hand hygiene (HH) prior to eating their meals.

A resident stated that staff did not remind them to wash hands or apply hand sanitizer prior to meals. The PSW indicated that resident HH was to be performed before and after meals. The PSW acknowledged that staff did not assist the residents in the home area with hand hygiene prior to the meal.

The IPAC lead acknowledged that the staff were supposed to assist the residents with HH again once the resident was in the dining room.

Inspector #741521 also observed residents on another home area were not supported to perform HH before eating their meals.

The risk of infection transmission was increased when staff failed to support residents with hand hygiene prior to meals.

Sources: Infection prevention and control - Routine Practices and Additional Precautions; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022; observations; and interview with resident, PSW, and the IPAC lead.

[741674]