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 # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_635600_0006	000455-15, 002313-16, 009649-16, 018255-16, 019681-16, 028396-16, 030150-16, 030472-16, 034552-16, 034856-16, 035143-16, 000001-17	Complaint

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET TORONTO ON M5A 2S3

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

DRS. PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET TORONTO ON M5A 2S3

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

GORDANA KRSTEVSKA (600), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 24, 27, 28, March 1, 2, and 3, 2017.

During this inspection complaints #000455-15, #002313-16, #009649-16, #018255-16, #019681-16, #028396-16, #030150-16, #030472-16, #034552-16, #034856-16, #035143-16, #000001-17, were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing Services (DNS), Director of Resident Care (DRC), Resident and Family Services Coordinator (RFSC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Service Manager (ESM), housekeeping staff, substitute decision makers (SDM) and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed clinical records, staff education records, critical incident system record, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Trust Accounts

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

3 WN(s)
1 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On an identified date inspector observed resident #005 having a meal in his/her room. The door was wide open and an identified sign had been placed on the door. There was no personal protective equipment (PPE) supply available before entering the room, or in the room. The resident needed assistance and PSW #111 who was leaving another resident's room, entered resident #005's room to assist. The PSW did not wash her hands and did not apply PPE, before he/she entered the room. When inspector asked for it, he/she noted that there was no PPE available around for him/her to use. The PSW exited the room, again not washing his/her hands and brought a plastic container specifically used for PPE.

Interview with PSW #111 revealed that he/she was not assigned to this resident to look after and was not aware why there was no PPE provided at the door because that is the practice in the home. The PSW confirmed that he/she knew the resident was on isolation and should have applied the PPE before entering the resident's room.

Interview with the DOC confirmed that when the resident is on isolation the staff are responsible to provide PPE beside the resident's door outside the room and staff are expected to practice infection control as per policy. [s. 229. (4)]

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 to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

Review of complaint submitted to the ministry of health and long term care (MOHLTC) on an identified date revealed that the complainant had emailed his/her concerns to the home, but did not receive a response from the home.

Interview with the complainant indicated that he/she had few concerns. The complainant indicated that he/she had emailed the concerns to the resident and family services coordinator (RFSC) last year.

Review of the Complaint and Response binder for 2016/2017, indicated that the above mentioned complaint was not filed in the binder and the complaint form was not completed.

Interview with the RFSC revealed that many families try to communicate with the home by email to speed up the process of solving concerns. The RFSC indicated that complaints received by e-mail are not entered in the Client Service Respond Form,

because the home either responds to the family by email or will verbally notify them about the progress of the investigation. Further the RFSC confirmed that the emails are not sent to the MOHLTC because they are not sure if it is complaint or whether the family is requesting assistance.

Review of the home policy titled General Procedures, #E-42, revised June 2013, under the purpose of the policy indicated that any written correspondence that outlines concerns will be identified as a complaint and will be forwarded by executive director (ED) to the MOHLTC within 10 business days and CSRF will be initiated.

Review of the RFSC's email with received concerns indicated that the complainant had sent an email to RFSC on an identified date with a few concerns. Further the review of the email revealed that the RFSC had responded to the complainant the same day acknowledging receiving the email and forwarded to the ED.

Interview with the ED and director of nursing (DNS) confirmed that they identify every written correspondence as a complaint. They indicated that they acknowledged the complaint from the identified family member and they work on solving the issues, but they did not forward the complaint to the MOHLTC. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Review of a complaint submitted to the MOH on an identified date, revealed that the complainant had asked the home for an equipment to be placed beside resident #005's bed as the resident had a few incidents with an injury. The complainant was told no by the home because of the risk to the resident might have different incident. Complainant did not know how that would happen as his/her father/mother requires two person to assist with some of the activity of daily living (ADL).

Record review revealed resident #005 was admitted to the home on an identified date and needed extensive assistance by one staff for most of the ADLs. On admission the resident had not been identified to be at risk for incidents.

Review of resident #005's written plan of care revealed that the resident had been identified to be at moderate risk for incident and interventions had been placed to prevent them. The resident had been followed by the intradisciplinary prevention team. One of the intervention to prevent incidents and injury was staff to check on resident every hour for safety.

Interview with PSW #111 revealed that the resident had the intervention in place and he/she checked on the resident hourly. The PSW indicated that he/she had not documented that intervention as there is no area in the point click care where he/she can document.

Interview with RN #106 confirmed that the resident was an identified intervention for safety and the staffs were not able to document this intervention as the task had not been set up in the electronic PSW daily record .

Interview with DNS confirmed the staff is expected to document the monitoring of the resident hourly. The DNS also confirmed that this intervention had not been set up in the electronic documentation records and therefore, confirmed that the PSW had not documented. [s. 30. (2)]

Issued on this 9th day of May, 2017

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

Original report signed by the inspector.