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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2019	2019_808535_0009	006344-19	Complaint

Licensee/Titulaire de permis

The Rekai Centres (fka Drs. Paul and John Rekai Centre)
345 Sherbourne Street TORONTO ON M5A 2S3

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

Sherbourne Place
345 Sherbourne Street TORONTO ON M5A 2S3

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

VERON ASH (535)

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): May 15, 16, 17, 2019.

The following intake was completed during this inspection: Log #006344-19 (related to abuse).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing Services (DNS), Behavior Support Lead (BSL), registered nurses (RN), registered practical nurse (RPN) and the resident.

During the course of the inspection, the inspector made observations related to staff to resident interactions and provision of care; conducted reviews of health records, staff education and training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 was protected from abuse by

anyone.

Ontario Regulation 79/10, s. 2 (1) (c) indicates emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on an identified date, related to staff to resident abuse.

Record review indicated resident #006 was assessed using the home's quarterly MDS Assessment Tool. The resident's plan of care included a focus related to their displayed responsive behaviors with interventions listed.

Record review of the Behavior Support Team's additional responsive behavior training included interventions to support the staff and resident interactions in order to prevent negative outcomes.

Record review, staff interviews and an interview with the complainant confirmed that on an identified date, resident #006 attempted an action that was prevented by PSW #114. The resident was not injured during the interaction.

During the inspection, PSW #114 was not available to be interviewed. However, during separate interviews, resident #006, registered staff RN #118, and observations made by the inspector verified that the incident occurred.

During the interview, resident #006 verified and a review of the progress notes confirm that the resident and PSW #114 engaged in negative interactions in the past; however the PSW was transferred to another unit by management.

During interviews, the Director of Nursing Services (DNS) and the Executive Director (ED) both verified that the incident occurred, and both stated that PSW #114 should not have engaged the resident in an identified action since they were aware of the resident's responsive behaviors. Therefore, the home failed to ensure that resident #006 was protected from emotional abuse by PSW #114. [s. 19. (1)]

2. While completing an interview during the complaint inspection, resident #006 informed the inspector about a situation which was currently occurring on their residing unit that

was causing them to be in distress.

According to resident #006, the situation started after an incident occurred between themselves and registered staff RPN #119.

Record review of the progress notes indicated that on an identified date and time, registered staff RPN #119 performed an action which upset the resident. Later that shift, RPN #119 refused to provide care to the resident while the resident was still under their care and supervision.

During an interview, registered staff RPN #119 verified that they had not provided care or service to the resident since the incident occurred months ago. The RPN also verified that they had attended specific training provided by the home's behavior support team which included intervention on how to work with the resident's responsive behaviors. Registered staff #119 further explained that they would tend to the resident if there was an emergency situation on the unit.

During an interview, registered staff #118 verified that they usually provide care to the resident at specified times; that resident #006 had specific responsive behaviors; and that all registered staff were trained to provide care to residents with a variety of responsive behaviors.

During an interview, the Director of Nursing Services (DNS) verified that registered staff #119 indicated that they did not want to provide an identified mode of care to resident #006 after the incident occurred; and that they arranged for another nurse to provide the care and service. The DNS also verified that the registered staff lack of interaction with resident #006 could be considered imposed social isolation, shunning, ignoring, and a lack of acknowledgement. Therefore, the home failed to ensure resident #006 was protected from emotional abuse by registered staff RPN #119. [s. 19. (1)]

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 resident #006 is protected from abuse by anyone, to be implemented voluntarily.

Issued on this 24th day of May, 2019

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

Original report signed by the inspector.