

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 Toronto Service Area Office 5700 Yonge Street, 5th Floor Toronto ON M2M 4K5 Telephone: 1-866-311-8002 TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date Inspection Number	July 20, 2022 2022_1247_0001	
Inspection Type		
□ Critical Incident System □ Critical Incident Sy	em □ Complaint □ Follow-Up	□ Director Order Follow-up
☐ Proactive Inspection	□ SAO Initiated	□ Post-occupancy
□ Other		
Licensee The Rekai Centres		
Sherbourne Place, Toro		
Lead Inspector Joy Ieraci (665)		Inspector Digital Signature

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 14, 15, 18 and 19, 2022.

The following intake was inspected:

 Log # 010772-22 (CIS #2754-000010-22) related to an injury to a resident with unknown cause.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)



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INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.102(8)

The licensee has failed to ensure that all staff participated in the implementation of the home's infection prevention and control program.

Rationale and Summary

The home's routine practices policy indicated that hand hygiene was the single most effective method of preventing the spread of infection. Staff were to encourage residents to perform hand hygiene or assist if they were unable, before and after meals.

Two residents' care plans indicated they were independent with eating.

A resident was provided a snack, and another resident was provided a meal without the PSWs encouraging or reminding them to perform hand hygiene.

One of the residents confirmed they did not perform hand hygiene prior to their meal.

IPAC Lead indicated that staff were required to assist, remind, or encourage residents to perform hand hygiene prior to meals and snacks.

There was a risk of infection transmission when the two residents were not reminded and encouraged to perform hand hygiene prior to meals and snacks.

Sources:

Resident Care Observations, review of residents' clinical records, Policy #IFC-B-15, titled Routine Practices, revised May 2, 2022, and interviews with IPAC Lead and other staff. [665]