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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 05, 2023	
Inspection Number: 2023-1247-0003	
Inspection Type: Critical Incident	
Licensee: The Rekai Centres	
Long Term Care Home and City: Sherbourne Place, Toronto	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature** Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.10.26 10:54:23 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26 - 28, 2023

The following intake(s) were inspected:

- Intake: #00085041, [Critical Incident System (CIS) report #2754-000005-23 related to medication management

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that training was provided to all direct care staff required by a Minister's Directive that applied to the long-term care home about its requirements.

Rationale and Summary

The Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, directed the homes to ensure that all direct care staff receive training on the requirements of the Directive.

The home's training records indicated that four registered staff members did not receive the training related to the requirements of the Directive.

There was a risk to the residents when the home's registered staff members did not receive the required training.

Sources: Staff training records, Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia updated on April 11, 2022, and interviews with staff members.

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WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the physician.

Rationale and Summary

A resident was prescribed a drug that specifically directed staff to administer it at a particular time of day. The staff member administered the drug not as directed, and the resident developed an adverse reaction.

The staff verified that they had administered the drug to the resident not as specified in the physician's order.

The Director of Resident Care (DORC) acknowledged that the staff member did not follow the physician's order, and was expected to administer the medication as directed by the physician.

The resident was at risk of an adverse reaction when the staff member administered the drug not as specified for its direction of use.

Sources: Critical Incident System (CIS) report, resident's clinical records, interviews with staff members.

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