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: April 16, 2024
Inspection Number: 2024-1247-0001
Inspection Type: Complaint Critical Incident Follow up
Licensee: The Rekai Centres
Long Term Care Home and City: Sherbourne Place, Toronto

Lead Inspector	**Inspector Digital Signature**
Carole Ma (741725)	Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2024.04.16 13:55:03 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4 - 5, 9 - 12, 2024

The following Complaint intake(s) were inspected:
- Intake: #00107559 – Related to abuse, theft, lack of assistance in purchasing goods

The following Critical Incident (CI) intake(s) were inspected:
- Intake: #00106516 - [CI 2754-000002-24] - Related to fall prevention and management

The following Follow Up intake(s) were inspected:

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- Intake: #00104037 - Compliance Order (CO) #001 related to Infection Prevention and Control

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1247-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Carole Ma (741725)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary

The licensee has failed to ensure that the plan of care was revised when a resident's care needs changed.

Rationale and Summary
A resident had a fall which resulted in a significant change in health status.

A physiotherapist (PT) assessment determined the resident could not safely use their assistive device and instead a different type of assistive device was provided.

On two separate occasions, the resident was observed using the updated assistive device with a monitoring device in place.

A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) indicated that before the fall the resident used the assistive device, but that after the fall they used the updated assistive device and a monitoring device for their safety.

The resident's care plan, however, continued to read that the resident used the assistive device, and that if they were seen without it for staff to provide it or remind the resident to use it. The care plan did not indicate the resident currently required the updated assistive device and a monitoring device.

The Director of Resident Care (DRC) acknowledged the care plan should have been updated immediately due to the resident's significant change in health status.

This non-compliance placed the resident's safety at risk.

Sources: Observations; resident's clinical records; Interviews with a PSW, RPN and DRC. [741725]