Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Original Public Report

Report Issue Date May 31, 2022
Inspection Number 2022_1442_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Rekai Centres

Long-Term Care Home and City
Wellesley Central Place
Toronto

Lead Inspector
Julie Ann Hing (649)

Additional Inspector(s)
Stephanie Luciani (707428)

Inspector Digital Signature
Julie A Hing
2022.06.14 15:27:33 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9, 10, 11, and 12, 2022.

The following intake(s) were inspected:

- Intake #0122283-21 (Complaint) related to Prevention of Abuse and Neglect.
- Intakes #019005-21 (CIS #2959-000021-21), #017657-21 (CIS #2959-000020-21), #016901-21 (CIS #2959-000019-21), #009276-21 (CIS #2959-000010-21), #009174-21 (CIS #2959-000009-21) related to Falls Prevention and Management.
- Intake #010048-21 (CIS #2959-000012-21) related to Plan of care.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the resident's plan of care related to the use of the call bell was provided to the resident as specified in the plan.

Rationale and Summary

A resident's written care plan indicated to ensure their call bell was within reach.

The resident was observed sitting in their wheelchair in their room and their call bell was not within their reach. The call bell was observed pinned to the cord behind the resident's bed out of the resident's reach. This observation was brought to the Registered Practical Nurse (RPN)'s attention who immediately ensure the resident's call bell was within their reach.

Failure to ensure that a resident's call bell was within reach may result in an increase in the risk of falls and delay in staff responding to care needs.

Sources: Resident's clinical records, Inspector #649's observations, and interviews with RPN and other staff. [649]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

(i) The licensee has failed to ensure that staff used Personal Protective Equipment (PPE) in accordance with Routine Practices and Additional Precautions.

Rationale and Summary

(a) A Personal Support Worker (PSW) was observed exiting a resident's room while wearing gloves. They performed hand hygiene while wearing their gloves, then brought a piece of transfer equipment back into the resident's room.

(b) A second PSW was observed exiting a resident's room wearing gloves, entered the clean the utility room to grab clean linen, then re-entered the resident's room wearing the same pair of gloves.

Infection Prevention and Control (IPAC) Lead and Director of Care (DOC) both indicated that staff are to remove their gloves prior to performing hand hygiene, and gloves are not to be re-used.

Failure of staff using PPE in accordance with routine practices and additional precautions increased the risk of disease transmission in the home.

Rationale and Summary

(ii) The licensee has failed to ensure that staff performed hand hygiene as required by routine practices.

(a) A PSW was observed returning the hoyer lift in the hallway and failed to perform hand hygiene after removing their gloves.

The home's policy titled "Hand Hygiene – Use of Alcohol Based Hand Rub" directed staff to perform hand hygiene as per the four moments of hand hygiene: after potential exposure to bodily fluids even if gloves were worn, and after contact with the patient or patient's environment.

IPAC Lead and DOC both indicated that staff are to perform hand hygiene after removing their gloves, and after contact with the resident's environment.

Failure to ensure staff perform hand hygiene as required by routine practices increased the risk of transmission of infection.

Sources: Observations, review of the home's Hand Hygiene Policy #IFC H-15-05, last revised April 2022, and interviews with IPAC Lead and other staff. [707428]

(iii) The licensee has failed to ensure that residents were assisted with hand hygiene prior to meal service.

Rationale and Summary

(a) Residents were observed entering the dining room. Staff did not assist or remind residents to perform hand hygiene prior to meal service.

The home's policy titled "Nutrition Services" directed staff to assist/remind all residents to wash/sanitize their hands before and after meals.

A PSW acknowledged that hand hygiene was not provided to residents before lunch. The PSW and the IPAC Lead both acknowledged that hand hygiene should be offered to all residents, and that residents should be assisted with hand hygiene before meals.

Failure to assist residents with hand hygiene increased the risk of transmission of infection.

Sources: Observation of lunch service on a home area, the home's policy titled "Nutrition Services" #N-10 revised date of September 2021, and interviews with the PSW and IPAC Lead. [707428]