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: September 19, 2023	
Inspection Number: 2023-1442-0005	
Inspection Type: Complaint Critical Incident	
Licensee: The Rekai Centres	
Long Term Care Home and City: Wellesley Central Place, Toronto	
Lead Inspector Joy Ieraci (665)	**Inspector Digital Signature** Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2023.09.20 12:50:55 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6, 7, 8, 11 and 12, 2023

The following intake(s) were inspected:

- Log #00093328 (Critical Incident System (CIS)) related to a fall with injury and;
- Log #00095292 (Complaint) related to resident-to-resident abuse.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1)

The licensee has failed to comply with their falls prevention and management program to reduce the risk of injury to a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a falls prevention and management program to reduce the incidence of falls and the risk of injury and must be complied with.

Specifically, staff did not comply with their policy "Post Fall Assessment Policy", last revised March 2023, which was included in the licensee's Falls Prevention Program.

Rationale and Summary

The policy stated that all residents will be assessed post falls to determine the extent and type of injury by the registered staff. The resident is to be assisted up if it has been assessed that the resident can be moved.

A resident had a fall which resulted in a transfer to hospital and sustained multiple injuries.

A personal support worker (PSW) moved an identified area of the resident's body twice prior to being assessed by the registered staff. The PSW indicated that it was the home's policy not to move the resident after a fall until they were assessed by the registered staff. They confirmed that they should not have moved the resident before being assessed.

The Director of Nursing Services (DONS) indicated that it was the home's policy that PSWs were not to move residents after a fall, until they were assessed by the registered staff for any injury. The PSW did not follow the home's fall's policy when they moved the resident.

There was a risk of further injury to the resident when the PSW moved the resident's body prior to being assessed by the registered staff after their fall.

Sources: Record review of the CIS report, Video Footage of Fall, the resident's clinical records and Post Fall Assessment Policy, last revised March 2023; and interviews with the PSW, DONS and other staff. [665]

WRITTEN NOTIFICATION: SECURITY OF DRUG SUPPLY

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

Rationale and Summary:

The medication room in one resident home area (RHA) was unlocked and a resident had opened the door and entered the room. A PSW and a PSW student re-directed the resident out of the medication room. There were mobile residents and staff in the area at the time of the observation.

The PSW indicated that the door was unlocked and there was no one in the medication room.

The Director of Nursing Services (DONS) indicated that the medication rooms were to be locked at all times when not in use.

There was a risk of harm to the resident if they had accessed medications in the medication room.

Sources: Medication room observation; and interviews with the PSW, DONS and other staff. [665]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Conduct weekly audits for four weeks for resident #002 to ensure that when the trigger for their

identified physical responsive behaviour towards co-residents is present, the specified intervention is implemented as per their plan of care, upon service of this order.

2. Maintain a record of the audits conducted, including residents and staff who were audited, the auditor, date(s) of the audits, results of the audit and any actions taken to address the audit findings.

Grounds

The licensee has failed to ensure that resident #001 was protected from abuse by resident #002.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

Rationale and Summary

Resident #002 displayed a physically responsive behaviour towards resident #001, which caused resident #001 to fall. Resident #001 was transferred to hospital and sustained multiple injuries.

Resident #002 had a history of physically responsive behaviours towards staff and residents. Six weeks prior to the incident, there were two occasions when the resident displayed physical behaviour towards residents #001 and #003.

At the time of the incident, resident #002’s plan of care indicated they had physical responsive behaviours towards others, the trigger was identified for the behaviour and an intervention to manage the behaviour.

The video footage of the incident showed resident #001 engaged in an interaction with resident #002. The trigger was displayed which resulted in resident #002's physical responsive behaviour. Resident #001 fell to the ground and screamed. PSWs #104 and #106 were in the area at the time of the incident.

PSW #106 indicated that resident #002 had a history of responsive behaviours towards other residents and attempted to be physically responsive to co-residents in the past. They identified resident #002’s trigger and the intervention to manage the behaviour. The PSW confirmed that they were aware that both residents were interacting with each other and did not implement the intervention. The PSW considered the incident to be physical abuse towards resident #001 by resident #002.

The Behavioural Support (BSO) Lead and DONS indicated that resident #002 had physically responsive behaviours and were aware of the trigger and the intervention to manage the behaviour. Both

confirmed that after viewing the video, the trigger was present during the residents' interaction and PSW #106 should have implemented the intervention as per resident #002's plan of care to prevent the incident from occurring.

There were significant injuries to resident #001 as a result of the responsive behaviour of resident #002. PSW #106 did not implement resident #002's intervention, which contributed to resident #002's behaviour towards resident #001.

Sources: Record review of CIS report, clinical records of three residents' and Video Footage of incident; and interviews with PSW, BSO Lead, DONS and other staff. [665]

This order must be complied with by November 7, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.