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
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Original Public Report

Report Issue Date: July 30, 2024	
Inspection Number: 2024-1442-0002	
Inspection Type: Critical Incident	
Licensee: The Rekai Centres	
Long Term Care Home and City: Wellesley Central Place, Toronto	
Lead Inspector Jack Shi (760)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 24, 25, 26, 2024

The following intakes were inspected:

- Intake: #00112369 - Critical Incident (CI)# 2959-000006-24 - related to an outbreak
- Intake: #00117132 - CI# 2959-000008-24 - related to a fall of a resident

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms were recorded on a shift.

Rationale and Summary
A resident was exhibiting symptoms over the course of three days. A review of the documentation indicated that the resident's symptoms were not documented on the progress notes on a specific shift during this period.

A Registered Practical Nurse (RPN) stated that residents who exhibited active symptoms would have their symptoms documented on the progress notes under the isolation precaution heading on every shift. The RPN acknowledged that they had missed documenting the resident's symptoms on one of their shifts.

After being interviewed by the inspector, the RPN followed up with a late-entry and

documented the resident's symptoms.

Failure to document a resident's active infection symptoms may lead to a delay in required treatments.

Sources: A resident's progress notes; Interview with an RPN. [760]

Date Remedy Implemented: July 25, 2024

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

(i) The licensee failed to ensure that alcohol-based hand rubs were not expired as part of the directive issued by the Chief Medical Officer of Health (CMOH).

Rationale and Summary
During observations, it was noted that there were two alcohol-based hand rubs located in two different resident home areas that had expired in March 2024. A Housekeeping Manager stated that staff were required to check if the product was expired and to notify a housekeeper. The IPAC (Infection Prevention and Control) Lead acknowledged that the alcohol-based hand rubs used by the home should not have been expired.

Failure to have non-expired alcohol-based hand rubs may reduce the efficacy of the product.

Sources: Observations on two resident units; Interview with the Housekeeping Manager and the IPAC Lead. [760]

(ii) The licensee failed to ensure that a housekeeper increased their cleaning and disinfection to at least twice daily in suspected or confirmed outbreaks as part of the directive issued by the CMOH.

Rationale and Summary
The home's policy titled, "Outbreak Infection Control –Common Areas", states that housekeeping aides will conduct frequent cleaning in all high touch common/resident areas in the home during a suspected or confirmed outbreak. A housekeeper told the inspector that they would clean and disinfect resident rooms and high touch surfaces once per day, even during an outbreak. The Housekeeping Manager stated that the housekeepers should be cleaning and disinfecting these areas at least three times during their shift when an area was in an outbreak. The IPAC Lead stated that the housekeeper would be required to clean and disinfect resident rooms and high touch surfaces more frequently and more education was required for this staff member.

Failure to enhance cleaning and disinfecting during an outbreak may lead to further spread of infectious diseases.

Sources: Policy titled, "Outbreak Infection Control –Common Areas", dated March 2024; Interview with a housekeeper, the IPAC Lead and the Housekeeping Manager. [760]