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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Public Report

Report Issue Date: January 24, 2025

Inspection Number: 2025-1442-0001

Inspection Type:
Complaint
Critical Incident

Licensee: The Rekai Centres

Long Term Care Home and City: Wellesley Central Place, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21, 22, 23 and 24, 2025.

The following intake(s) were inspected:
- Intake: #00128705 / Critical Incident Systems (CIS) 2959-000010-24 was related to alleged physical abuse
- Intake: #00128767 / CIS 2959-000011-24 was related to improper care of resident
- Intakes #00130342 / CIS 2959-000012-24, #00130877 / CIS 2959-000013-24, #00134783 / CIS 2959-000014-24 and #00136028 / CIS 2959-000001-25 were related to an outbreak

The following complaint intake was inspected:
- Intake: #00131983 was related to dealing with complaints.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

On an identified date, one resident struck another resident resulting in harm to that resident. The home's investigation notes and interview with the DOC confirmed that an incident of resident-to-resident abuse occurred.

Sources: Interview with DOC, Progress Notes, CI Report and the home's Investigation notes.
[741716]

WRITTEN NOTIFICATION: Food production

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78

(3).

The licensee has failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods to, prevent adulteration, contamination and food borne illness when a PSW portered food to residents without placing a protective cover on them.

A PSW was observed portering food via food warmer to residents in their rooms. Eleven small plates with food were noted on top of the food warmer without coverings. The PSW acknowledged that they did not cover residents food prior to transporting it to them. Failure to keep food covered for residents on tray service placed them at risk of adulteration, contamination and food borne illness.

Sources: PSW observation, the home's policy #C011 titled, "Meal Service for Residents Eating in Their Rooms", revised June 2024, interview with the PSW. [698]