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: June 24, 2025
Inspection Number: 2025-1442-0003
Inspection Type: Proactive Compliance Inspection
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): June 10-13, 16-18, 20, 24, 2025.

The following intake as inspected:
Intake: #00149339 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain 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. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas on two different Resident Home Areas (RHAs) were kept closed and locked when they were not being supervised by staff.

i) On June 10, 2025, the clean utility room door on a RHA was unable to lock during an observation.

On June 12, 2025, the door lock was repaired.

Sources: Observations of a RHA on June 10, 2025; interviews with the home's staff and management.

ii) On June 10, 2025, multiple gloves were observed inside the door strike plate, which prevented the door from locking on a RHA. The gloves were removed by staff immediately after the observation, and the door was able to be locked.

Sources: Observations of a RHA on June 10, 2025; interview with the home's staff.

Date Remedy Implemented: June 12, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(b) is on at all times;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times. On June 11, 2025, the call bell system on the balcony of a RHA was not functional.

The call bell was fixed later that date on June 12, 2025.

Sources: Observation of a RHA on June 11, 2025; and interviews with the home's staff and management.

Date Remedy Implemented: June 12, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (6) (a)
Continuous quality improvement initiative report
s. 168 (6) The interim report prepared under subsection (5) must,
(a) be published on the home’s website, subject to section 271;

The licensee has failed to ensure that the 2024-2025 Continuous Quality Improvement (CQI) Initiative Report was posted on the home's website.

The CQI report was posted on the home's website on June 18, 2025.

Sources: Home's website, interviews with the home's management.

Date Remedy Implemented: June 18, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (6) (b)
Continuous quality improvement initiative report
s. 168 (6) The interim report prepared under subsection (5) must,
(b) be provided to the Residents' Council and Family Council, if any; and

The licensee has failed to ensure that the copy of the 2024-2025 CQI Report was provided to the Resident and Family Councils.

A copy of the CQI report was provided to the Resident and Family Councils on June 18, 2025.

Sources: Resident Council Binder, interviews with the home's management.

Date Remedy Implemented: June 18, 2025

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure a resident was monitored for their response to, and the effectiveness of, their pain management strategies.

A resident's plan of care stated to complete a specific monthly evaluation for pain monitoring on the specific day of each month. There was no monthly pain evaluation completed on a specified date. A staff member acknowledged that they did not complete the monthly pain evaluation on the specified date.

Sources: Review of a resident's clinical records, and interview with the home's staff.