Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 11, 2014	2014_357101_0022	T-530-14	Complaint

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3

Long-Term Care Home/Foyer de soins de longue durée

WELLESLEY CENTRAL PLACE
160 WELLESLEY STREET EAST, TORONTO, ON, M4Y-1J2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDA WILLIAMS (101)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 23, 2014

During the course of the inspection, the inspector(s) spoke with The Executive Director, the Director of Administrative Services, the Director of Clinical Services, the Food Service Manager, the Environmental Manager and the Director of Nursing Services.

During the course of the inspection, the inspector(s) reviewed the home's emergency plans policies and procedures; documentation of tests completed of emergency plans; and observed the home's resources, supplies and equipment set aside for emergencies.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home
Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff receive retraining on an annual basis related to emergency and evacuation procedures as evidenced by:

- record review and interview with the Executive Director and the Director of Administrative Services identified that the home has not completed education for any emergency procedures in 2013. In addition, the home was unable to provide evidence of education completed in emergency plans prior to 2013 as the current management team was not present in the home until 2013 and were unable to locate any documentation to confirm that such education was conducted prior to their arrival. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff are trained annually in emergency plans so that they are made aware of what actions to take in cases of all emergencies, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home. O. Reg. 79/10, s. 230 (4).

s. 230. (5) The licensee shall ensure that the emergency plans address the following components:
1. Plan activation. O. Reg. 79/10, s. 230 (5).
2. Lines of authority. O. Reg. 79/10, s. 230 (5).
3. Communications plan. O. Reg. 79/10, s. 230 (5).
4. Specific staff roles and responsibilities. O. Reg. 79/10, s. 230 (5).

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

s. 230. (7) The licensee shall,
(a) test the emergency plans related to the loss of essential services, fires, situations involving a missing resident, medical emergencies and violent outbursts on an annual basis, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(b) test all other emergency plans at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency; O. Reg. 79/10, s. 230 (7).
(c) conduct a planned evacuation at least once every three years; and O. Reg. 79/10, s. 230 (7).
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans. O. Reg. 79/10, s. 230 (7).

Findings/Faits saillants :

1. The licensee failed to ensure resources, supplies and equipment vital for the emergency response are set aside and readily available at the home in cases of emergencies as evidenced by:

- observation of dietary food supplies and interview with the Food Service Manager

identified that food supplies are not set aside in cases of emergencies. The entire home's food supply was observed to be stored together. The Food Service Manager stated that extra food supplies are purchased above the required daily food supply in cases of emergencies but are not kept separate or set aside. [s. 230. (4) 3.]

2. The licensee failed to ensure that emergency plans to addresses lines of authority was current and up to date. Review of the lines of authority list available to staff noted that roles such as the Environmental Manager and the Executive Director were several years out of date. [s. 230. (5)]

3. The licensee failed to ensure that emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information as evidenced by:

- record review of the home's emergency policy and procedures available to staff confirmed that the manual was last reviewed in January 2007. Interview with the Executive Director (ED) and review of the ED's copy of the emergency plans policy and procedure manual confirmed that the home's management team last reviewed the emergency plans policy and procedures in February 2014 but have not yet circulated the updated policies to staff. [s. 230. (6)]

4. The licensee failed to ensure that a) the emergency plans are tested on an annual basis related to the loss of essential services, situations involving a missing resident, medical emergencies and violent outbursts, including the arrangements with the community agencies, partner facilities and resources that will be involved in responding to an emergency,
(b) all other emergency plans are tested at least once every three years, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency,
(c) a planned evacuation is conducted at least once every three years, and
(d) a written record is maintained of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans as evidenced by:

- interview with the Executive Director and review of the home's documentation of completed emergency tests confirmed that the home has not conducted test of any emergency plans on an annual basis or once every three years; and
- interview with the Executive Director confirmed that the home has not conducted a planned evacuation in the home within the past three years. The Executive Director

has been in the home and in the role since November 2013 and was unable to locate paperwork to confirm that the home has completed an evacuation in the past 3 years. It was noted that the home has scheduled a planned evacuation for June 2014. [s. 230. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 1. all staff participate in tests of emergency plans so that they are made aware of and take appropriate action in cases of emergencies and 2. that evaluations of the tests are completed and records maintained of changes made to improve the plans, to be implemented voluntarily.

Issued on this 11th day of June, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs