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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 05, 2015;	2014_297558_0022 (A1)	T-021-14	Resident Quality Inspection

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

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

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

NATASHA JONES (591) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 9-12, 15-18, 22, 23, 29, 2014.

The following intakes were completed concurrently with the RQI.

T-519-14, T-1015-14, T-416-13, and T-677-13.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of nursing services (DNS), director of care (DOC), resident assessment instrument (RAI) coordinator, food service manager (FSM), registered dietitian (RD), physiotherapist (PT), family and resident services coordinator (FRSC), director of environmental services (DES), director of programs and volunteer services (DPVS), registered nurse (RN), registered practical nurse (RPN), personal service worker (PSW), dietary aide (DA), life enrichment aide (LEA), maintenance worker, receptionist, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

12 WN(s)
3 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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 #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

On December 11, 2014, resident #06 was observed laying in bed with bed rails engaged. A review of the resident's MDS assessment and staff interviews identified the bed rails are used by resident #06 for bed mobility. A staff interview revealed the use of bed rails and the number of bed rails required would be identified in the written plan of care. A registered staff member confirmed the use of bed rails would be located in the written plan of care under the bed mobility focus.

A record review and staff interviews confirmed the written plan of care did not indicate the use of bed rails.

An interview with the DOC confirmed the use of bed rails should be indicated in the written plan of care. [s. 6. (1) (c)]

2. On December 11, 2014, resident #03 was observed laying in bed with bed rails engaged. A review of the resident's MDS assessment dated November 8, 2014, and

staff interviews identified the bed rails are used by resident #03 for bed mobility. A staff interview revealed the number of bed rails required would be identified in the written plan of care. A registered staff member confirmed the use of bed rails would be located in the written plan of care under the bed mobility focus.

A record review and staff interviews confirmed the written plan of care did not indicate the use of bed rails.

An interview with the DOC confirmed the use of bed rails should be indicated in the written plan of care. [s. 6. (1) (c)]

3. On December 18, 2014, resident #13 was observed laying in bed with two quarter side rails in the up position.

Record review of the residents plan of care did not include direction for the use of side rails.

Interviews with two PSWs revealed that the resident uses two side rails to assist with positioning in bed, and the PSWs stated that the resident's care plan did not include direction related to side rail use. Interviews with the DOC and the PT revealed that the resident uses two side rails to assist with positioning in bed, and therefore the side rails should be in the plan of care with direction for use as a PASD.

The DOC and the PT confirmed that the plan of care did not set out clear direction to staff. [s. 6. (1) (c)]

4. On a specified date and time, the inspector observed two identified PSWs preparing resident #31 for transfer using a yellow edge sling using a mechanical lift from the bed to the wheelchair. The resident was observed to become agitated and began to yell out. The PSWs attempted to calm the resident during the transfer.

Resident is at high risk for falls related to poor judgment, unable to weight bear and responsive behaviours when being transferred by staff from bed to wheelchair and vice versa.

Record review of the written care plan indicates three persons for physical assist with mechanical lift. Resident would sometimes become restless while being transferred by mechanical lift. One staff to operate machine and two staff to hold and guide resident.

Interviews with PSWs revealed conflicting information regarding the number of staff required to transfer resident #31. Some staff indicated the resident requires three staff to transfer the resident at all times as the resident is often agitated and exhibits responsive behaviours during care including transfers, while other staff indicated the resident requires three staff to transfer if the resident becomes restless.

Interviews with the PSWs revealed that the resident requires two persons for transfer. One of the identified PSWs referred to the POC kardex and confirmed that the care plan does not reflect the transfer that was carried out and further indicated he/she understood that only if the resident becomes restless that a third staff member can be called to assist.

Interview with an another identified PSW and the PT confirmed that the resident is a three person transfer.

Interview with the falls prevention lead and an identified registered staff confirmed that although the resident's care plan indicates three persons for transfer with mechanical lift that most of the time the resident is a two person transfer, and if the resident becomes restless, they can call for additional assistance.

The DNS indicated that the resident's care plan was revised after a fall with injury in July 2014, from two to three staff transfers by mechanical lift if the resident becomes agitated or restless. The DNS indicated that the resident usually has two persons providing transfers as a third staff may not be available on all shifts and that perhaps it needs to be revised to reflect the practice more clearly. [s. 6. (1) (c)]

5. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #05 is identified with responsive behaviours related to smoking. The resident's written care plan indicates resident is permitted to have a specified number of cigarettes in a 24 hour period to maintain resident's budget and a month's supply of cigarettes. Furthermore, the resident's written care plan indicates a specific schedule of receiving cigarettes and that only registered staff are permitted to give resident scheduled cigarettes. A main supply of cigarettes is kept at reception. The reception staff supplies one cigarette package to nursing to keep in the medication drawer as needed. Cigarettes are not to be dispensed by the receptionist unless instructed to do so by the charge nurse. When the resident demonstrates behaviours, PSW and registered staff are to implement the interventions as outlined in the written care plan.

An interview with the one of the home's receptionists revealed that the resident regularly sits by the receptionist waiting and requests cigarettes. The receptionist is aware that only the registered staff is permitted to dispense cigarettes to the resident and indicated that he/she has given the resident a cigarette (from the supply kept at reception) when the resident has demonstrated behaviours.

Interview with registered staff and personal support staff revealed only the registered staff is permitted to dispense cigarettes to the resident and that the receptionist is not permitted to dispense cigarettes to the resident but to send resident upstairs to get her scheduled cigarette.

Interview with the DNS confirmed that the resident has a strict cigarette smoking schedule as a means to manage the resident's responsive behaviours and only registered nurses are permitted to dispense cigarettes to the resident unless otherwise directed by the registered staff. [s. 6. (7)]

6. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

A record review indicated and family interview revealed that at admission, weight loss was deemed desirable for resident #21.

A record review and staff interview revealed that the resident had lost 10kg and during one of the resident's multidisciplinary care conferences, the substitute decision-maker requested a new goal weight range to maintain the resident's weight. A record review did not locate a nutritional assessment to determine whether the resident's nutritional intake was adequate to support the resident's new goal weight range.

An interview with the RD confirmed resident #21's nutritional status was not reassessed when the resident's goal weight changed.

Resident #21 experienced subsequent weight loss below the requested goal weight range on specified dates in 2013 and 2014.[s. 6. (10) (b)]

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
- the written plan of care sets out clear directions to staff and others who provide direct care to the resident
- the care set out in the plan of care is provided to the resident as specified in the plan
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Residents' Council receives a written response within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of Residents' Council minutes for the July 2014 meeting identified a complaint regarding the use of shower curtains and a recommendation was made. A review of Residents' Council minutes dated August 12, 2014, revealed this complaint did not receive a response and was re-issued. The Residents' Council minutes dated September 16, 2014, revealed a third re-issue pertaining to the same complaint. On September 23, 2014, a Residents' Council concern form was completed and signed by the Residents' Council president.

An interview with the DPVS confirmed that the process for handling a complaint raised during Residents' Council is that a concern form is initiated, it is directed to the appropriate department head, a response is provided within five days and then approved by the ED within an additional five days. The completed form is then brought to the Residents' Council president to review and sign. The DPVS could not locate a Residents' Council concern form for the July or August 2014 complaint. [s. 57. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in behaviour management.

Record review and interview with the RAI coordinator confirmed that 35 out of 88 staff did not receive training in behaviour management in 2013. [s. 76. (7) 3.]

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 who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in behaviour management, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Staff interviews confirmed that the licensee did not seek the advice of the Residents' Council in developing and carrying out the 2013 satisfaction survey. [s. 85. (3)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

On December 15, 2014, the inspector observed that on the following dates, the vaccine fridge temperatures were not recorded in the vaccine temperature log book.
- December 14, 2014
- October 9,10,12,14,15, 2014
- September 2,7,11,14,19,21, 2014.

Record review of the policy titled medication administration storage of vaccines F-50 revised April 30, 2014, indicated that for the refrigerator used for storage of vaccines there will be documented temperature checks completed twice daily by the charge nurse on the day and the evening shifts.

An interview with the DNS confirmed that the policy was not complied with. [s. 8. (1) (b)]

2. The inspector observed resident #07's motorized wheelchair and walker seats to be soiled with food stains on December 10, 2014. On December 23, 2014, it was observed that the resident's motorized wheelchair foot rest was soiled with food stains.

A review of the home's policy entitled equipment cleaning/repairs RCSM M-30 indicates the following:

1. It is the responsibility of the personal support workers (PSWs) on the night shift to clean all wheelchairs, geri-chairs, walkers, footwear, urinals, and commodes weekly as per the cleaning schedule using the approved cleaning and disinfection products.
2. The night charge nurse must check all cleaned equipment.
3. All spills are to be wiped off immediately by the staff member who observes it.
The outcome indicates that all equipment is cleaned as per established scheduled.

Interviews with identified registered staff and PSWs revealed that residents' personal equipment is to be cleaned on the night shift when the resident has had a scheduled bath/shower. The identified PSW confirmed that resident #07's motorized wheelchair foot rest was soiled.

Record review and interviews with staff confirmed there is no evidence of a cleaning schedule. One registered staff indicated that the POC kardex for residents with personal equipment should identify the cleaning schedule and confirmed that there is no cleaning schedule identified on the POC kardex for residents #07 and #08.

An interview with the DNS confirmed that it is an expectation of the home that cleaning of resident ambulation equipment is to be identified as a task on the POC and document the completion of the task. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure proper techniques are used to assist the resident with eating, including safe positioning of residents who require assistance.

On December 17, 2014, at approximately 12:00 p.m., the inspector observed in the main dining room during lunch, an identified PSW assisting resident #05 with eating, sitting on an elevated feeding stool. Within 5 minutes, a second PSW took over the task of feeding the resident and did not adjust the feeding stool. The resident had to raise his/her head to receive food. The FSM was informed and brought over a regular dining room chair for the staff as the feeding stool could not be lowered. There were no available adjustable feeding stools. The resident is at nutritional risk, requiring total eating assistance related to uncontrolled movement due to a specified diagnosis resulting in swallowing and choking/aspiration problems.

A review of the home's policy, entitled feeding a dependent resident G-80-1, revised April 30, 2014, indicated that staff sit in a chair beside resident facing him/her at eye level.The registered staff confirmed that all staff must be seated with the residents at eye level to ensure safe feeding techniques are applied.

Interview with the DNS and the FSM revealed that the home is in the process of purchasing additional feeding stools and adjustable dining tables. [s. 73. (1) 10.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the complaint that cannot be resolved within 10 business days, a date by which the complainant can reasonably expect a resolution is provided.

An interview with resident #03's power of attorney (POA) revealed a report had been filed regarding missing items belonging to resident #03. A record review revealed a client service response form was initiated on November 25, 2014, for the identified missing items. The form indicated a search was carried out on or before November 27, 2014, and the missing items were not found. The form indicated that on December 5, 2014, the complainant was notified by the FRSC that "we are still looking into it". The form did not include a date by which the complainant could reasonably expect a resolution.

An interview with the FRSC confirmed that a date by which the complainant could reasonably expect a resolution was not provided. [s. 101. (1) 2.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes any follow-up action required.

An interview with resident #03's power of attorney (POA) revealed a report had been filed regarding missing items belonging to resident #03. A record review revealed a client service response form was initiated on November 25, 2014, for the identified missing items. The form indicated a search was carried out on or before November 27, 2014, and the missing items were not found. The form indicated that on December 5, 2014, the complainant was notified by the FRSC that "we are still looking into it".

Interviews with the POA and FRSC revealed the missing items would be featured in an upcoming newsletter. The FRSC indicated the newsletter would be issued in January 2015. A record review revealed the documented record did not include this follow-up action required. [s. 101. (2)]

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Record review of the bed entrapment audit dated March 17, 2014, by Joerns company, revealed that the bed used by resident #13 failed. A summary of the document revealed that 128 beds were tested, 30 beds passed, 86 beds failed, and 12 beds were not tested. The suggested solutions presented in the assessment summary included replacing the failing beds and/or replace the mattresses.

On December 23, 2014, interviews with the DES and the DRS revealed that 56 of the 86 beds that failed the entrapment audit had not yet been replaced and steps had not been taken to prevent resident entrapment. [s. 15. (1) (b)]

2. Resident #03 was observed to have two bed rails in use. A review of the bed assessment summary conducted by Joerns company, dated March 17, 2014, revealed resident #03's bed failed entrapment zones 3 and 7. The suggested solutions presented in the assessment summary included replacing the failing beds and/or replace the mattresses. The report revealed resident #03's mattress or bed had not been replaced.

An interview with the DNS confirmed this resident's mattress or bed had not been replaced and no steps taken to prevent resident entrapment at this point in time. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specified date, resident #31 suffered a fall while being transferred using the wrong sling. The resident fell through the sling, onto the floor and sustained an injury. The resident was transferred to hospital and returned the same day in stable condition. The care plan was revised requiring three persons for physical assist with the mechanical lift. Resident would sometimes become restless while being transferred by mechanical lift. One staff is to operate the machine and two staff are to hold and guide resident. The care plan was later revised requiring staff to use a sling with yellow border for transfers with mechanical lift.

Interview with the PSW who was involved in the incident indicated that during the transfer, the resident became agitated and subsequently fell through the sling because it was too big and too loose. The PSW confirmed they did not check to ensure the correct sling was used before initiating the transfer. The PSW confirmed that the sling size was not identified on the written care plan prior to the fall.

Interview with the DNS indicated that according to the home's investigation, the staff transferred the resident correctly however when the sling was examined, it was observed to be too big for the resident. The DNS indicated that the findings of the home's investigation revealed that the resident's correct sling which was yellow edged was sent to the laundry and incorrectly replaced with a green edged sling. The staff did not ensure the correct sling was being used prior to the transfer and it was determined that the PSW staff involved in the incident were not aware that the rim/edge of the sling determines the size. [s. 36.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are provided training in falls prevention and management.

Record review and interview with the DOC confirmed that 2 of 87 (2.3%) of all direct care staff did not receive training on falls prevention and management in 2013. [s. 221. (1) 1.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

On December 22, 2014, the inspector observed that the bathroom call bells for resident #02 and resident #12 were not easily accessible.

On December 22, 2014, an interview with resident #12 revealed that the bathroom call bell had been inaccessible to him/her since admission to the home.

Record review of the home's intranet system revealed that an audit of the nurse call system for the entire home was conducted on January 16, 2014, by contracted services Insta-Tech.

On December 23, 2014, an interview with the DES revealed that the call systems identified by the contractor as malfunctioning were corrected by the same contractor however if the issue was the replacement of the call bell string used by the resident to activate the call system, he did the replacements. The DES stated that the contractor is scheduled to come in for their annual inspection next month, and that the staff are responsible to alert maintenance of any malfunctioning call bells by submitting a requisition online via the intranet maintenance system.

On December 22, 2014, an interview with the maintenance worker revealed that the above mentioned call bells were not easily accessible and stated that they would be corrected within a day or two. An interview with the DRS revealed that the above mentioned call bells were not easily accessible, that requisitions had been submitted for their correction, and that staff on all floors had been directed to check all resident bedroom and bathroom call bells for accessibility and if issues were noted to submit a requisition to maintenance.

On December 23, 2014, the inspector observed that the above mentioned malfunctions had been corrected by the home. [s. 17. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. 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. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times

On December 21, 2014, the inspector observed the basement doors at the east and west exits leading to stairways were unlocked. The basement is a resident home area and residents can access the stairways through the unlocked doors, which presents a risk of falling. Interviews with two identified maintenance workers revealed that the above mentioned doors require mag-locks and should be locked at all times.

On December 22, 2014, an interview with the administrator revealed that the head office is aware of the unlocked exit doors leading to stairways in the home and the home is in the process of obtaining contractor quotes for the doors to be corrected. The administrator confirmed that the above mentioned doors are not locked, and are not in compliance with O.Reg 79/10, s. 9. (1) of the Act.

On December 23, 2014, an interview with the DES revealed that the above mentioned doors were unlocked and that the home has received approval to hire a contractor to secure the doors. [s. 9. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 5 day of May 2015 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : NATASHA JONES (591) - (A1)

Inspection No. / No de l'inspection : 2014_297558_0022 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : T-021-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 05, 2015;(A1)

Licensee / Titulaire de permis : DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3

LTC Home / Foyer de SLD : DRS. PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Deslyn Jack

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To DRS PAUL AND JOHN REKAI CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that summarizes the following:

1. Short term actions to mitigate risks to residents who are currently residing in a
bed that has failed one or more entrapment zones, including residents who use
a therapeutic surface.

2. Long term actions to ensure that each bed remains free of entrapment zones
including a maintenance strategy to ensure that each bed is inspected as per

manufacturer's instructions to maintain the bed in good condition.

Please submit the plan to Barbara.Parisotto@ontario.ca and Natasha.G.Jones@ontario.ca by February 17, 2015.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #03 was observed to have two bed rails in use. A review of the bed assessment summary conducted by Joerns company, dated March 17, 2014, revealed resident #03's bed failed entrapment zones 3 and 7. The suggested solutions presented in the assessment summary included replacing the failing bed and/or replace the mattress. The report revealed resident #03's mattress or bed had not been replaced.

An interview with the DNS confirmed the resident's mattress or bed had not been replaced and no steps were taken to prevent resident entrapment at this point in time. (558)

2. Record review of the bed entrapment audit dated March 17, 2014, by Joerns company, revealed that the bed used by resident #13 failed entrapment zones 2 and 4. A summary of the document revealed that 128 beds were tested, 30 beds passed, 86 beds failed, and 12 beds were not tested. The suggested solutions presented in the assessment summary included replacing the failing bed and/or replace the mattress. The report revealed resident #13's mattress or bed had not been replaced.

On December 23, 2014, interviews with the DES and the DRS revealed that 56 of the 86 beds that failed the entrapment audit had not yet been replaced and steps had not been taken to prevent resident entrapment. (591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Mar 31, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. 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.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

(A1)

The licensee shall prepare, submit and implement a plan to ensure that all doors leading to stairways and to the outside of the home are kept closed and locked, and are equipped with a door access control system that is kept on at all times.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are,
i. kept closed and locked,
ii. ii. equipped with a door access control system that is kept on at all times.

On December 21, 2014, the inspector observed the basement doors at the east and west exits leading to stairways, unlocked. The basement is a resident home area and residents can access the stairways through the unlocked doors, which presents a risk of falling. Interviews with two identified maintenance workers revealed that the above mentioned doors require mag-locks and should be locked at all times.

On December 22, 2014, an interview with the administrator revealed that the head office is aware of the unlocked exit doors leading to stairways in the home and the home is in the process of obtaining contractor quotes for the locks to be installed. The administrator confirmed that the above mentioned doors are not locked, and are not in compliance with O.Reg 79/10, s. 9. (1) of the Act.

On December 23, 2014, an interview with the DES revealed that the above mentioned doors were unlocked and that the home has received approval to hire a contractor to secure the doors. (591)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

May 31, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning techniques when assisting resident #31. Please submit plan to Tiina.Tralman@ontario.ca, by February 17, 2015.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specified date, resident #31 suffered a fall while being transferred using the wrong sling. The resident fell through the sling, onto the floor and sustained an injury. The resident was transferred to hospital and returned the same day in stable condition. The care plan was revised requiring three persons for physical assist with the mechanical lift. Resident would sometimes become restless while being transferred by mechanical lift. One staff is to operate the machine and two staff are to hold and guide resident. The care plan was later revised requiring staff to use a sling with yellow border for transfers with mechanical lift.

Interview with the PSW who was involved in the incident indicated that during the transfer, the resident became agitated and subsequently fell through the sling because it was too big and too loose. The PSW confirmed they did not check to ensure the correct sling was used before initiating the transfer. The PSW confirmed that the sling size was not identified on the written care plan prior to the fall. Interview with the DNS indicated that according to the home's investigation, the staff transferred the resident correctly however when the sling was examined, it was observed to be too big for the resident.

The DNS indicated that the findings of the home's investigation revealed that the resident's correct sling which was yellow edged was sent to the laundry and incorrectly replaced with a green edged sling. The staff did not ensure the correct sling was being used prior to the transfer and it was determined that the PSW staff involved in the incident were not aware that the rim/edge of the sling determines the size. (162)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Feb 27, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5 day of May 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NATASHA JONES - (A1)

Service Area Office /
Bureau régional de services : Toronto