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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2015	2015_440210_0007	T-1657-15	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

SLAVICA VUCKO (210), JUDITH HART (513), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, and 18, 2015.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Nursing Services (DONS), Director of Resident Care (DORC), Resident Service Coordinator, Registered Dietitian (RD), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Environmental Services Manager (ESM), Resident Council President and Vice-president, substitute decision makers (SDM), residents and family members of residents, performed a tour of the home, reviewed residents' records and home's policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #002	2014_297558_0022	162

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 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 kept closed and locked.

On August 4, 2015, at approximately 10:30 a.m., in the basement level which residents have access to, the inspector observed several doors unlocked. The door to the housekeeping supply closet containing cleaning supplies\chemicals was not fully closed and accessible. The beauty salon was used to store several boxes of donated items and was found to be unlocked and accessible. Furthermore, the inspector observed the receiving door to the loading dock with a drop to a lower level, was unlocked. The inspector observed a sign posted by the receiving door which indicated, "Please ensure that this door is locked and the alarm is on at all times." There were no deliveries taking place at the time of the observation and no staff in the vicinity of the unlocked doors.

An interview with the ESM and maintenance staff #138 shortly after the above-mentioned observations confirmed that the housekeeping supply door and beauty salon door must be locked when not in use. As well, the receiving area door must be locked and the alarm activated when not in use. The ESM locked the receiving door and reset the alarm. The ESM locked the beauty salon door and ensured the housekeeping supply door was locked.

On August 6, 2015, at approximately 3:40 p.m., the inspector observed the receiving door unlocked and the alarm not activated. The inspector entered the receiving dock area. There were no deliveries taking place at the time of the observation. There was no staff in the vicinity.

Interviews with the DORS and the ESM shortly after the above-mentioned observation revealed that the receiving area door is frequently left unlocked and the alarm deactivated pending a delivery.

An interview with the ED on August 7, 2015, confirmed the receiving door was not always kept locked due to frequent deliveries and that door will be kept locked and alarm activated. On August 18, 2015, the ED and ESM confirmed a bell was installed on the delivery side of the receiving door to notify of a delivery and for staff to unlock the door. The inspector confirmed the bell was installed. [s. 9. (1)]

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 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, kept closed and locked, equipped with a door access control system that is kept on at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On August 13, 2015, at approximately 5:00 p.m., during the evening medication administration, the inspector observed that resident #41`s medication packets were placed in a bin on the side of the cart.

An interview with registered staff #120 revealed that she would gather the bags of empty medication packets at the end of the shift, tie the bag with a knot and place it in the unit garbage bin, located in the locked soiled utility room. The registered staff indicated that housekeeping would remove the garbage from the soiled utility room to the waste receptacle located at the loading dock for disposal. An interview with the DONS revealed that the empty medication packets would be taken by the garbage collection to a recycling depot and then taken to the waste management dump site.

The DONS confirmed that the resident`s personal health information was not fully protected and kept confidential according to the Act and that the home is looking into methods to remove the resident name from the medication packets before discarding them. [s. 3. (1) 11. iv.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. On August 5, 2015, at approximately 10:30 a.m., inspector #210 observed resident #31 lying in the bed and eating breakfast. The head of the bed was positioned at approximately 45 degree angle. The resident was observed to be lying flat on the bed with only her shoulders and her head upright and her chin resting on her chest. The resident was also observed to have difficulty accessing her food from the over-bed table because she was not able to see the food because of her positioning.

A review of the resident's written care plan initiated February 21, 2015, revealed that the resident prefers to eat in her room, and staff are to ensure the head of the bed is elevated to at least a high to semi-fowler position during meal times, at risk for aspiration and required intermittent supervision.

An interview with the resident revealed she had no complaints with eating in her current position in bed.

An interview with PSW #117 confirmed that the resident was not in an upright position while eating.

Interviews with registered staff #100, the RD and the DONS confirmed that the resident is at high risk for swallowing problems and aspiration, and required to be positioned upright during meal times. [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Over the course of the inspection, the inspector observed that the following:

Fourth floor spa room:
-Shower stall floor safety strips ripped and worn off,
-Two ceiling air exhaust vents covered with thick coating of dust deposit,
-Cracked plastic corner wall protector at the right side of the entry door,
-Coving at the head of the tub area pulled away, with drywall/plaster coming free,
-Broken tiles at the bottom of the wall by the toilet,
-Water damage and dark stains on and around the door frame of the clean utility room.
-On August 17, 2015, the inspector observed water leaking from the ceiling above the door frame, and towels were placed on the floor to absorb the water. Interview with the ESM indicated the central air conditioner will be replaced next month.
Lounge/Activity room:
-Vinyl chair right armrest ripped,

Third floor spa room:
-Water stained ceiling tiles above the tub area and peeling paint on the wall below the water stained ceiling tile,
-Missing cover from the electric baseboard exposing metal heaters located underneath the sink,
-Missing wall tile midway up the wall next to the toilet,
-Broken tile at the bottom right side of the wall next to the entry,
-Two ceiling air exhaust vents covered with thick coating of dust deposit,
-Nursing unit counter chipped corner,
-Loose plastic corner wall protector at entrance to room 319,
-Sink counter chipped in room 301 bedroom.

Second floor Spa room:
-Water stained ceiling tile above the tub,
-Two air exhaust on ceiling are filled with thick coating of dust deposit,
-Coving on the wall by the door is pulled away, with drywall/plaster coming free,
-Toilet base with dried caulking and debris surrounding the base and the flooring in room 212.

An interview with the ESM confirmed that the above-mentioned were not maintained in a

good state of repair and that the ESM will be putting in a plan for repairs. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items are labelled within 48 hours of acquiring.

On August 4, 2015, the inspector observed an unlabelled toothbrush, toothpaste and body lotion on the counter by the sink in an identified room shared washroom.

An interview with registered staff #108 confirmed that the identified personal items were not labelled. An interview with the DONS confirmed that personal items are to be labelled including toothbrushes, toothpaste and body lotion when residents share a washroom. [s. 37. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

A review of the admission minimum data set (MDS) assessment for resident #12 from an identified date, revealed that the resident was frequently incontinent of bowel and occasionally incontinent of bladder.

An interview with registered staff #108 indicated a continence assessment tool is to be completed on admission for every resident and when there is a change in the resident's urinary continence status.

A record review including the bladder and bowel assessment forms, and interview with registered staff #108, confirmed that resident #12 who was incontinent was not assessed using the clinically appropriate assessment instrument to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

An interview with the DONS confirmed that the expectation is when the resident is incontinent on admission or if the resident`s health status changed the resident's continence should be assessed using the clinically appropriate assessment instrument. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the home`s Resident Satisfaction Survey revealed that the satisfaction for the nursing programs is measured by the question on the survey, " the nursing services meet resident's needs" and "nursing staff is knowledgeable about my care and needs".

A review of the home`s Family Satisfaction Survey revealed that the satisfaction for the nursing programs is measured by the questions: " nursing services are provided in a caring and compassionate manner", " nursing staff have discussed the topic of cardiopulmonary resuscitation (CPR)/level of intervention with resident/family /family member".

A review of the resident and family satisfaction survey for 2014 and interviews with the ED and DONS confirmed that the resident and family satisfaction survey did not measure satisfaction with nursing programs including pain, skin and wound management, continence care, falls and restraints. [s. 85. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for cleaning of the home, including resident bedrooms, floors, common areas, and carpets.

Fourth floor:
-Dark stains around caulking in front of toilet in washroom of room 415.

Third floor spa Room:
-Dark stains around stripping that runs around the parameter of the left shower stall.

Second floor spa room:
-Dark stains around the base of the toilet,
-Dark stains around stripping that runs around the parameter of the left shower stall.
-Black stains along the bottom of the shower nylon curtain.

Chapel:
-Multiple carpet stains throughout.

An interview with housekeeping staff #119 revealed that resident washrooms and spa rooms are cleaned with cleanser and disinfectant daily. An interview with the ESM revealed that the current cleaning was not effective in managing the build-up of dark stains. Further interview with the ESM revealed that the scheduled cleaning of the carpet including spot cleaning was not effective. [s. 87. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

On August 4, 2015, at approximately 2:30 p.m., the inspector observed a bottle of Lysol toilet bowl cleaner on the counter by the sink in the shared washroom of room #214. The inspector informed registered staff #134 who immediately removed the chemical.

Interview with housekeeping staff #118 revealed staff are only to use chemicals that are identified on the home's WHMIS list and approved for use by the ESM.

Interview with the ESM confirmed that Lysol toilet bowl cleaner is not identified on the home's WHMIS list and not approved for use by housekeeping staff.

On August 12, 2015, on the third floor, the inspector observed Vim cleanser and two bottles of Febreeze air freshener in the housekeeping cart. An interview with housekeeping staff #119 revealed that she uses these identified products. The staff member confirmed she purchased Vim to clean the third floor spa room sink and that she uses Febreeze where odours are detected in resident`s rooms. The housekeeping staff confirmed that these products are not approved by the ESM for use in the home.

An interview with the ESM revealed that Vim and Febreeze products are not permitted for use by housekeeping staff. [s. 91.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies that is secure and locked.

On August 14, 2015, at 10:22 a.m., the inspector #513 observed in resident #42's room a bottle of identified tablets on the bedside table.

An interview with registered staff #104 confirmed that the medications were not stored in a secure and locked area exclusively for drugs and drug related supplies. An interview with the DONS confirmed that all medications must be kept in the medication room or the medication cart that are always locked. [s. 129. (1) (a) (iii)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On August 14, 2015, at 10:22 a.m., the inspector observed in resident #42's room a bottle of identified tablets on the bedside table.

An interview with registered staff #104 confirmed that there was no physician prescription for the identified tablets. An interview with the DONS confirmed that a physician prescription was required in consultation with resident #42, in order for the resident to self-medicate. [s. 131. (5)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participate in the implementation of the infection prevention and control program.

On August 4, 2015, inspector #162 observed a sign for contact precautions posted on the door to an identified room followed by inspector #210`s observation on August 5, 2015 that the sign was removed.

A review of the resident #08's clinical record including the diagnoses by inspector #513 identified that the resident was diagnosed with a specified condition, however there was no written care plan identifying the condition. A review of the current written plan of care revealed that there was no indication of the specified condition including interventions.

Interviews with PSW #134 and registered staff #101 confirmed they were not aware that resident #08 had a specified condition. PSW #134 indicated that she uses gloves when providing direct care but does not use a gown or mask.

An interview with the DONS confirmed that the resident has a specified condition and that the resident's contact precautions should be in place unless there are four negative test results as per the home's policy for the management of the specified condition, revised December 12, 2014.

Further interview with the DONS confirmed that a written care plan is required for the resident with the specified condition and confirmed that the written care plan should not have been cancelled on August 1, 2015, and that staff should have continued to follow the contact precautions. [s. 229. (4)]

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Issued on this 16th day of September, 2015

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

Original report signed by the inspector.