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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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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
Jan 31, 2017	2016_251512_0016	029799-16	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

TILDA HUI (512), JULIEANN HING (649)

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): October 12, 13, 17, 18, 19, 20, 21, 24, 25, 26, and November 8, 2016.

The following critical incidents were inspected concurrently with this inspection: 008305-16 related to abuse, 010076-15-related to falls, 002537-15-related to elopement, 031282-16 related to safe and secure home.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Nursing Services (DNS), Director of Resident Care (DRC), Food Service Manager (FSM), Director of Environmental Services (DES), Director of Residents`Programs, Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Receptionist, Personal Support Workers (PSWs), Life Enrichment Aide (LE), Dietary aides (DAs), Housekeeping Aide, Laundry Aide, residents, family members and substitute decision makers.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes, and review of the home's policies and procedures, Family and Residents' Council meeting minutes, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

11 WN(s)
6 VPC(s)
2 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 #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #023 was protected from abuse by staff in the home.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by anyone other than a resident that causes physical injury or pain.

This inspection was initiated in relation to an identified critical incident (CI) submitted of an allegation of a staff to resident abuse on an identified date. Resident #023 reported to his/her family member that a PSW handled him/her roughly during toileting on an identified shift. The resident was transferred to the hospital with an injury.

An interview with the identified family member of resident #023 who indicated on the identified date and time, resident #023 rang the call bell and waited to be toileted for about 30 minutes, one staff came in and brought the resident in the wheelchair to the washroom. When finishing toileting, resident #023 was transferred from the toilet to the wheelchair again and according to what the resident told his/her family member he/she was banged against a furniture item. The resident's roommate overheard resident #023 crying out, and the staff was heard saying an inappropriate comment to the resident. The staff brought resident #023 back to bed and left. Resident #023 told his/her family member that he/she was handled roughly. The incident was reported to the Director of Nursing Services (DNS) the next day. The home initiated an immediate investigation.

Review of the home`s investigation notes revealed the home had interviewed all staff on the unit on duty on the identified date and the days before and after the identified date. PSWs interviewed were consistent in indicating that they did not toilet resident #023 during those few days and nights as resident #023 was weak from an identified medical

condition. However, review of the documentation program's audit summary for the week of the identified date, indicated resident #023 was toileted consistently during the identified days during the week.

Review of the resident's written plan of care with an identified date, revealed the resident required two staff to toilet and transfer even though the resident could weight bear. The resident had history of an identified medical condition and was on an identified treatment.

Review of resident #023`s discharge summary from the hospital dated six days after the incident, revealed an injury consistent with the resident’s complaint which was described by the resident to his/her family member.

Interviews with RPN #127, who was on duty at the time when the incident was reported by the family member, recalled speaking to PSW #141 who was on duty with PSW #142 at the identified date and time of the incident. PSW #141 confined to RPN #127 that PSW #142 went to toilet resident #023 by him/herself, the resident lost balance during transfer, PSW #142 held onto the resident and lifted the resident up and put him/her on the wheelchair.

During a telephone interview, PSW #141, told the Inspector that on the identified date and time of the incident, he/she did not come close to resident #023`s room and did not have knowledge of what happened. Interview with PSW #142 stated he/she did not toilet resident #023 on the identified date and time but instead offered the resident a bedpan which the resident declined. PSW #142 stated he/she told the resident to urinate in his/her incontinent brief and PSW #142 would return to change the resident later. PSW #142 stated he/she always documented what he/she had done for residents for the shift in Point-of-Care (POC). PSW #142 terminated the conversation with the Inspector when asked the reason for his/her documentation showing that PSW #142 had toileted the resident on the identified date and time of the incident as recorded in the POC audit report.

An interview with the DNS and the DOC confirmed that resident #023 had suffered injury as result of an incident occurred on the identified date and time, during which the resident was handled roughly by PSW #142.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more unrelated non-compliance

issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 19. (1)]

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. 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

Inspection was initiated after the doors to the laundry room at the basement level were observed to be left open with no staff inside twice during the course of the inspection. The laundry room was equipped with two doors, one at both ends of the room. Drums of chemicals were observed inside the laundry room connected to the washing machines. A hair salon for residents and a resident's recreation room were located across the hallway from the laundry room.

Observation was made on an identified date and time during the inspection, revealed the doors to the laundry rooms were closed but not locked. There were no staff inside the laundry room. A resident was observed sitting in the hair salon at the time and was in clear view of the laundry room. The Inspector waited for five minutes and did not see any staff in the vicinity. An identified management staff of the home came out from the kitchen down the hallway and was approached by the Inspector. The management staff

stated the laundry room doors were supposed to be locked when not supervised by staff. The management staff stated the laundry staff must have gone home by that time and proceeded to lock the laundry room doors. The management staff stated he/she will inform the Inspector's observation to the Director of Environmental Services (DES). Interview with the DES confirmed the laundry room doors were to be locked when staff finished their shift. [s. 9. (1) 2.]

2. Observation made at an identified date and time during the inspection revealed the door on the housekeeping room on an identified unit was found unlocked. The following chemicals were observed in the room:

-Green Earth Daily Floor Cleaner on the wall dispenser
-Betco Fastdraw Daily Disinfectant SC on the wall dispenser
-Spray bottle of Accel TB on the floor
-Bottle of Shinner Spray Buff on the floor

An interview with Housekeeping Aide #103 confirmed that the housekeeping door should be locked at all times. An interview with RN #101 revealed that residents on the identified unit did wander around the unit.

An interview with the DES #102 stated that the housekeeping door should be kept locked when unattended to ensure that hazardous substances are kept inaccessible to residents at all times. [s. 9. (1) 2.]

3. This inspection was triggered by a Critical Incident report submitted to the Ministry of Health and Long-term Care (MOHLTC) of an incident where resident #029 was found having fallen with his wheelchair into the loading dock at the home on an identified date and time.

Review of the CI report revealed the resident was found by security guard from the nearby building at the identified time at the bottom of the loading dock with his/her wheelchair overturned. The security guard called 911 and notified the RN on duty. The resident was assessed by RN #120 to have sustained injuries to several parts of his/her body and was transferred to hospital. The resident returned after 24 hours and continued to receive monitoring at the home. The home had initiated an investigation of the incident.

Observation of resident #029 during the inspection period revealed the resident with no

visual scars nor bruising and with no complaints of pain. The resident was not able to be interviewed related to cognitive impairment.

Resident #029's written plan of care with an identified date was reviewed. The resident ambulated in wheelchair and can propel him/herself around the unit and off floors. The resident was described as at high risk for falls. There were focus, goal and interventions set up to address the resident's risk for falls including hourly safety checks on all shifts. Review of the resident's safety check record revealed that on the day of the incident, resident was last checked for his/her where about and was toileted at 35 minutes before the incident time. Then the resident was seen by RN #120 on the ground floor and refused to go back to his/her unit when the RN tried to encourage him/her to.

During an interview, the Executive Director (ED) indicated that the home had completed the investigation of the incident. The ED reviewed the video footage of the security camera which showed the inside door from the hallway to the loading dock was always locked with a red light indicating it was locked. Staff entering the door would have to use their access swipe card to unlock the door with the light turned green. After entering the door, staff were supposed to use the swipe card to lock the door and turned the light to red before they leave the door. However on the day of the incident, video footage showed staff entering and leaving the door from an hour and a half prior to the incident, did not need to use the swipe card and they did not check to see if the light returned to red after they use the door. The resident was seen entering the door at two minutes before the incident and was found fallen into the dock at the identified incident time. The camera did not cover the dock area so how the resident fell was not able to be seen. The ED interviewed the staff identified as entering and leaving the doors at the time. Three of the four staff interviewed stated that they had noticed the door light stayed green around the time of the incident and did not report to anyone, thinking another staff would have reported it. The ED stated the home had just installed a new software for the security camera and was not able to produce a copy of the video for the inspector. The ED provided a video surveillance report to the Inspector with the sequences of events as described by the ED.

The Inspector interviewed Housekeeping Aides #103, and #145 who were on duty on the day of the incident. During the interviews, Housekeeping Aides #103 and #145 indicated that they noticed the door leading to the loading dock was not locked when they entered and exited the doors between 40 minutes prior to the incident time on the day of the incident. Both Housekeeping Aides did not report the doors were left unlocked to anyone, and both said they thought another staff would report it.

Interview with the DES indicated staff were expected by the home to report malfunctioning of any doors leading to non-residential areas. Interview with the ED confirmed that the home has failed to ensure doors leading to non-residential areas were locked when they were not being supervised by staff.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more non-compliance in similar areas issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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

On an identified date during the inspection, the Inspector observed PSW #115 perform hand hygiene, apply gown and gloves prior to providing care to resident #015 who had an isolation cart and an identified additional precaution sign outside of his/her room.

A review of resident #015's written plan of care with an identified date revealed that there was no focus in the written plan of care to direct staff and others on what precautions should be followed when providing care to resident #015.

During interview RN #114 told Inspector that resident #015 had been diagnosed with a medical condition and staff should practise an identified additional precautions when providing care to the resident. RN #114 further confirmed that resident #015's written plan of care had not been updated to provide any direction to staff and others on what precautions should be taken during care.

Interview with DNS #113, lead of the Infection Prevention and Control program, and DRC

#118 confirmed that resident #015’s care plan had not been updated to provide clear directions to staff and others on what precautions should have been taken when providing care to resident #015. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other.

An identified CI report was submitted to the MOHLTC related to resident #005 who had gone missing on an identified date and time. The CI report further indicated that resident #005 was found 10 hours later by a nurse outside of the nearby subway station and he/she informed the police and resident was taken back to the home. Upon resident #005's return to the home, a head to toe assessment was completed, found that resident #005 had obvious signs of injury and was transferred to hospital for assessment.

During interview RN #101 revealed that on the day of the incident resident #005 had expressed intentions to leave the home to another location while they were both outside of the home. RN #101 told the Inspector that he/she immediately brought resident #005 back into the building and notified the receptionist, dietary staff, and all the PSWs working on the unit of resident #005's intentions to leave the building. RN #101 further stated that he/she had instructed PSW #139 to stay with resident #005 and other PSWs would cover his/her assignment for the rest of the shift to ensure the resident's safety. At around eight minutes before the identified time, resident #005 was not in his/her room and after searching the building was unable to locate resident #005 and code yellow was called.

At an interview receptionist #125 told Inspector that he/she could not recall being told by RN #101 of resident #005's intentions to leave the home on the identified date. Interviews with Dietary Aides #134, #136, and #137 were unable to recall being told by RN #101 of resident #005's expressed intentions to leave the home. During interview PSW #139 told Inspector that he/she was unable to recall if they had been told by RN #101 to watch resident #005 and stated that if he/she was told to do so by RN #101, he/she would have followed the direction they had been given.

A review of resident #005's progress notes revealed an entry dated two days before the resident was noted missing, the resident had signed himself/herself out of the home and could not be found when the resident was to be picked up for an outing. Resident #005

was located three hours later at the identified outing location. A further review of resident #005's most recent smoking assessment dated two years prior to the incident date that resident had been allowed to go outside of the home to smoke and did not require any supervision or monitoring. Resident #005 had not been reassessed after he/she eloped on the incident date, and continued to have the same privileges to go outside and smoke unsupervised/monitored.

Interview with Life Enrichment (L.E) Aide #110 told Inspector that while he/she was covering the lunch break at reception two dates prior to the incident date, he/she had let resident #005 out of the home to go out for a smoke. L.E #110 further stated that he/she had not been aware of resident #005's expressed intentions to leave the home and also was unaware that resident #005 had eloped from the home two days prior to this incident, and had been missing for a couple of hours.

Interview with DNS #113 and DRC #118 confirmed that staff on duty on the unit at the time of the incident and staff covering reception during lunch relief had not collaborated with each other to ensure resident #005's safety. [s. 6. (4) (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 there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

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 has failed to ensure that 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.

The inspection was triggered at stage one during interviews when two residents told the Inspector that they had seen cockroaches in their washrooms.

Home's policy titled Pest Control, policy number C-16, last reviewed date August 2013,, was reviewed. The policy statement stated the Rekai Central shall monitor pest sightings and report and record all incidents of sightings to their immediate supervisor for follow up. In the Procedure section, item #1 stated staff members who sight a pest are required to complete the form, specifically noting date, time of sighting, what was sighted, where it was sighted.

An interview with RPN #105 revealed he/she had seen cockroaches around the nursing station of an identified floor on an identified date. The RPN admitted he/she did not report the sighting to his/her immediate supervisor as required by the home's policy. The RPN stated he/she had forgotten how to report pest sighting even though he/she had received training at orientation.

Review of the home's Pest Sighting and Reporting Log did not reveal sighting report in the identified month from RPN #105. The DES provided emails messages from nursing staff on the identified floor for the identified month, which did not include any message forwarded by RPN #105.

Interviews with the DES and the ED confirmed that RPN #105 had not complied with the home's policy of reporting on pest sighting. [s. 8. (1)]

2. Review of the home's policy titled Medication Administration, Index I.D F-05 with a revised date of August 9, 2016, revealed under the section titled "Signature and Initials" that "all medications administered must be signed off electronically as given by the registered staff as soon as the medications have been given".

During the RQI while conducting the narcotic counts the following observations were made:

(a)On an identified date and time during the narcotic count with RN#101 on a specified unit, it had been observed that resident #014's narcotic medication did not match the number of tablets on the narcotic card.

Interview with RN #101 revealed that he/she had given resident #014's his/her narcotic medication 65 minutes earlier and had not signed the narcotic sheet at the time the medication had been administered to the resident.

(b)On a second identified date and time during the narcotic count with RPN #105 on a specified unit, it had been observed that resident #015's narcotic medication did not match the number of tablets on the narcotic card.

Interview with RPN#105 revealed that he/she had given resident #015's narcotic medication 10 minutes earlier and had not signed the narcotic count sheet at the time the medication had been administered to the resident. A review of resident #015's medication administration record (MAR) obtained from Point Click Care (PCC) revealed that RPN #105 had signed resident #015's MAR at 20 minutes prior to the identified time.

(c) On a third identified date and time during the narcotic count with RPN #111 on a specified unit, it had been observed that resident #017's narcotic medication did not match the number of tablets on the narcotic card.

Interview with RPN #111 revealed that he/she had given resident #017's his/her narcotic medication three hours earlier and had not signed the narcotic count sheet at the time the medication had been administered to the resident.

Interview with DNS # 113 and DRC #118 confirmed that nurses' #101, #105, and #111 should have signed the narcotic sheets at the time the medications had been administered to residents #014, #015, and #017 and therefore the home's medication policy had not been complied with. [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 that 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 #5: 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 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

This inspection was triggered at stage one of the RQI where resident #011 was identified as having a continence decline from the admission Minimum Data Set (MDS) assessment as compared with the 90 days post admission assessment.

Record review of the home's continence assessment found on PCC documentation system revealed that there was no incontinence assessment for resident #011's using a clinically appropriate assessment instrument specifically designed for assessment of incontinence since admission.

An interview with the RAI Coordinator #121 and RPN #129 indicated that it has been the home's practice that residents who are continent at admission do not receive a continent assessment, instead the home does a bowel and bladder study to determine the resident's pattern. RAI Coordinator #121 and RPN #129 further stated if a resident is incontinent when admitted he/she should receive a bowel and bladder assessment and a bowel and bladder study to determine the resident's pattern.

Interviews with RAI Coordinator #121, RPN #129, and RN #124 revealed that resident #011 had been identified as frequently incontinent of bladder in the resident's written plan of care dated six months after admission. Review of the resident's assessment list did not reveal any bladder and bowel incontinence assessment having been conducted on the resident according to the home's practice.

An interview with the DNS #113 and the DRC #118 confirmed resident #011 should have received an incontinent assessment of his/her bladder function by using a clinically appropriate assessment instrument specifically designed for assessment of bladder incontinence upon his/her admission. [s. 51. (2) (a)]

2. This inspection was triggered at stage one of the RQI where resident #007 was identified as having a continence decline from the admission MDS assessment as compared with the 90 days post admission assessment.

Review of resident #007's MDS assessment dated on admission revealed the resident was assessed as usually continent. The MDS assessment dated four months after admission, assessed the resident as frequently incontinent. Review of the resident's written care plan dated three months after admission, indicated the resident having urinary incontinence requiring one staff's extensive assistance to toilet and the use of incontinent products.

Review of the resident's assessment record on point-click-care (PCC) did not reveal a bladder and bowel continent assessment conducted on the resident, using a clinically appropriate tool that is specifically designed for assessment of incontinence, on or after the identification of the resident's deterioration in bladder incontinence by two levels during the two identified MDS quarterly assessment.

An interview with RPN #129 indicated the resident's bladder function was described as frequently incontinent and requiring extensive assistance of one staff to toilet. The RPN stated he/she was not sure why the assessment was missed as he/she knew that one such assessment had to be conducted on residents with incontinence status changes according to the home's practice.

An interview with RN #114 who is the lead for the Incontinence Program, stated that staff were expected to conduct a bladder and bowel incontinent assessment using the home's clinically appropriate assessment instrument on the resident upon identification of changes in incontinence levels. An interview with the DNS confirmed that the above mentioned assessment was not conducted on resident #007 who had experienced incontinence deterioration. [s. 51. (2) (a)]

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 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: 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. (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).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council, in developing and carrying out the satisfaction survey and acting on it's results.

During the Residents' Council interview, the inspector interviewed resident #024 who was the past RC representative, and resident #025 the current RC representative. Both residents revealed that the home had not consulted the RC in developing and carrying out the last satisfaction survey. During an interview, resident #026 who is the current RC President indicated that he/she could not recall the home seeking RC's advice prior to carrying out the survey.

Review of the available RC meeting minutes for 2015/2016 revealed no documentation of the home having consulted the RC on the questionnaire used for residents' satisfaction survey prior to implementation in 2016.

An interview with the Executive Director (ED) indicated he/she was not aware that RC had to be consulted on the satisfaction survey and therefore did not seek the advice of the Residents' Council prior to implementation. [s. 85. (3)]

2. The licensee has failed to ensure that the results of the satisfaction survey were documented and made available to the Residents' Council in order to seek the advice of the Council about the survey.

During the Residents' Council interview, the inspector interviewed resident #024 who was the past RC representative, and resident #025 the current RC representative. Both residents revealed that the home had not provided to the RC the results of the last satisfaction survey. During an interview, resident #026 who is the current RC President indicated that he/she could not recall the home provided to the RC the results of the last satisfaction survey at the RC meetings.

Review of the available RC meeting minutes for 2015/2016 revealed no documentation of the home provided to the RC the results of the satisfaction survey conducted in 2016.

An interview with the ED indicated he/she was not aware that RC had to be provided with the results of the satisfaction survey and therefore did not present it to the Residents' Council. [s. 85. (4) (a)]

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 advice of the Residents' Council in developing and carrying out the satisfaction survey was sought, and that the results of the satisfaction survey were documented and made available to the Residents' Council in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #7: 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 were used exclusively for drugs and drug-related supplies.

During the observation of the medication pass the Inspector observed the following non-drug related supplies stored in the narcotics drawer while conducting the narcotic counts on two identified units:

(i) On an identified date and time during the inspection, the Inspector observed on the first identified unit, the following non drug-related items in the narcotic drawer of the medication cart:

-An ink for e-pen
-Two pairs of scissors
-An envelope with $75.00 belonging to resident #016

An interview with RN #101 stated that the above mentioned non drug-related items should not have been stored in the narcotic drawer of the medication cart.

(ii) On a second identified date and time during the inspection, the Inspector observed on the second identified unit the following non drug-related items in the narcotic drawer of the medication cart:

- A greeting card in envelope
- A bunch of small zip lock plastic bags
- An empty envelope for e-pen refills
- An employee incident report form

An interview with RPN #111 indicated the above mentioned non drug-related items should not have been stored in the narcotic drawer of the medication cart.

An interview with DNS #113 and DRC #118 confirmed the above mentioned non drug-related items should not have been stored in the narcotic drawer of the medication cart that were being used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that were used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

This inspection was triggered for resident #007 during stage one of the RQI with report of a continence decline in the resident's MDS assessment at 90 days after admission.

Review of resident #007's MDS assessment with an identified date, indicated resident was incontinent of bladder and continent of bowel function. Review of the resident's written care plan dated the same week, did not reveal strategies including focus, goal and interventions to manage the resident's bowel continence.

An Interview with PSW # 128 indicated the resident required reminder to go to the washroom, and was able to toilet himself at times. The resident was often found incontinent of urine when incontinent products were changed, but had never been found to be incontinent of bowel when changed. The PSW indicated the resident often went out of the home and did not return until a few hours later. And so it was challenging to track his/her bowel movement. An Interview with RPN #129 revealed similar challenges. The RPN agreed that having strategies included in the resident's written care plan would benefit the provision of care, and was surprised to see that how the strategies were missed.

An interview with the DNS confirmed the resident's plan of care was not based on an interdisciplinary assessment of the resident's continence, including bowel elimination. [s. 26. (3) 8.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that responses in writing were made within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council (R.C.) meeting minutes revealed concerns raised at three identified meetings were not addressed within 10 days of receiving the following concerns:

- Concern raised that show plates were not shown to residents who were a little late going into the dining room and resident was given something of the staff's choice, not the resident's. There were no documentation to support that this concern was responded to.
- Concern raised that toast is only being toasted on one side of bread. This concern was not responded to by the Food Services Manager until the next meeting.
- Concerns raised that RC members felt they were not being spoken to in a respectful way and felt they were being lectured at. R.C. members felt staff were very sarcastic towards them. Some Council members were refused care close to shift changes. Other concerns raised included Council members had some issues around the noise level after 10 p.m., they felt they were too loud, and personal laundry were often found in other residents' rooms. These concerns were not responded to by the DNS until 14 days after the concerns were raised as documented on the RC Concerns Form .

Interviews with the DNS and ED confirmed that the above mentioned concerns raised at the RC meetings were not responded to within 10 days of receiving the concerns. [s. 57. (2)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home assisted in the establishment of a Family Council within 30 days of receiving a request from a family member or person of importance to a resident.

Review of the home's quarterly information session minutes revealed an identified family member of resident #028's had expressed interest to be part of the home's Family Council (FC) on the feedback form after the information session held on an identified date. The home's Social Worker returned call to the family member and obtained consent to release his/her contact information to any potential Family Council organizer.

An interview with resident #028's family member indicated he/she was willing to assist with the setting up of the FC. However no follow up action had taken place since the identified meeting. The family member attended another information session three months later and again there were no follow up actions regarding the setting up of the FC .

An interview with the ED indicated he/she was not aware of the request to set up FC as the Social Worker was appointed as the liaison for the FC and the request was not brought to the ED's attention. Interview with the Social Worker indicated that he/she was not aware of the relevant legislative requirement and therefore did not follow up with the setting up of the F.C.

The ED confirmed that the home had not assisted in the establishment of a Family Council within 30 days of receiving a request from a family member or person of importance to a resident. [s. 59. (3)]

WN #11: 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 staff participate in the implementation of Infection prevention and control program.

On an identified date during the inspection, the Inspector observed the following unlabelled personal care items in a shared bathroom in an identified room :

-One toothpaste
-One toothbrush
-One shaving cream

Interview with PSW #100 revealed it was an expectation that resident's personal items are kept at the resident's bedside and should be labelled to reduce the risk of infection.

Interview with RN #101 confirmed that resident's personal items should not have been in the shared bathroom but kept at the resident's bedsides and these items should have been labelled.

Interview with the DNS #113, lead of the Infection Prevention and Control program, and the DRC #118 confirmed that the residents' personal care items should have been labelled and kept at the residents' bedside in order to reduce the risk of infection. [s. 229. (4)]

Issued on this 24th day of February, 2017

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

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

Ministére 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TILDA HUI (512), JULIEANN HING (649)
Inspection No. / No de l'inspection :	2016_251512_0016
Log No. / Registre no:	029799-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 31, 2017
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Colette Cameron

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:

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

Ministére 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 : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident #023 is protected from abuse by anyone and to ensure that the resident is not neglected by the licensee or staff.

The plan shall include, but not limited to the following:

1. Resident #023's requests for assistance with toileting will be provided in a manner that is consistent with his/her assessed needs and will be delivered to the resident free from any abuse.
2. A process to evaluate the above mentioned strategy to ensure effectiveness in providing quality and safe care to the resident.
3. Development of a plan which will include a schedule to test and monitor staff's performance in adherence to the home's zero tolerance of abuse and neglect program.

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to tilda.hui@ontario.ca by February 28, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #023 was protected from abuse by staff in the home.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), the use of physical force by anyone other than a resident that causes physical injury or pain.

This inspection was initiated in relation to an identified critical incident (CI) submitted of an allegation of a staff to resident abuse on an identified date. Resident #023 reported to his/her family member that a PSW handled him/her roughly during toileting on an identified shift. The resident was transferred to the hospital with an injury.

An interview with the identified family member of resident #023 who indicated on the identified date and time, resident #023 rang the call bell and waited to be toileted for about 30 minutes, one staff came in and brought the resident in the wheelchair to the washroom. When finishing toileting, resident #023 was transferred from the toilet to the wheelchair again and according to what the resident told his/her family member he/she was banged against a furniture item. The resident's roommate overheard resident #023 crying out, and the staff was heard saying an inappropriate comment to the resident. The staff brought resident #023 back to bed and left. Resident #023 told his/her family member that he/she was handled roughly. The incident was reported to the Director of Nursing Services (DNS) the next day. The home initiated an immediate investigation.

Review of the home`s investigation notes revealed the home had interviewed all staff on the unit on duty on the identified date and the days before and after the identified date. PSWs interviewed were consistent in indicating that they did not toilet resident #023 during those few days and nights as resident #023 was weak from an identified medical condition. However, review of the documentation program's audit summary for the week of the identified date, indicated resident #023 was toileted consistently during the identified days during the week.

Review of the resident's written plan of care with an identified date, revealed the resident required two staff to toilet and transfer even though the resident could weight bear. The resident had history of an identified medical condition and was on an identified treatment.

Review of resident #023`s discharge summary from the hospital dated six days after the incident, revealed an injury consistent with the resident's complaint which was described by the resident to his/her family member.

Interviews with RPN #127, who was on duty at the time when the incident was reported by the family member, recalled speaking to PSW #141 who was on

duty with PSW #142 at the identified date and time of the incident. PSW #141 confined to RPN #127 that PSW #142 went to toilet resident #023 by him/herself, the resident lost balance during transfer, PSW #142 held onto the resident and lifted the resident up and put him/her on the wheelchair.

During a telephone interview, PSW #141, told the Inspector that on the identified date and time of the incident, he/she did not come close to resident #023`s room and did not have knowledge of what happened. Interview with PSW #142 stated he/she did not toilet resident #023 on the identified date and time but instead offered the resident a bedpan which the resident declined. PSW #142 stated he/she told the resident to urinate in his/her incontinent brief and PSW #142 would return to change the resident later. PSW #142 stated he/she always documented what he/she had done for residents for the shift in Point-of-Care (POC). PSW #142 terminated the conversation with the Inspector when asked the reason for his/her documentation showing that PSW #142 had toileted the resident on the identified date and time of the incident as recorded in the POC audit report.

An interview with the DNS and the DOC confirmed that resident #023 had suffered injury as result of an incident occurred on the identified date and time, during which the resident was handled roughly by PSW #142.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more unrelated non-compliance issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 19. (1)]

(512)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

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 :

The licensee shall prepare, submit and implement a plan to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The plan shall include, but not limited to the following:

1. Policy and procedure to direct staff to monitor all doors leading to non-residential areas
2. Communication plan for the policy to be shared with staff
3. A schedule to test and monitor staff's performance in adherence to the home's policy related to the monitoring of doors leading to non-residential areas

The plan is to include the required tasks, the person responsible for completing the tasks and the time lines for completion. The plan is to be submitted to tilda.hui@ontario.ca by February 28, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

This inspection was triggered by a Critical Incident report submitted to the Ministry of Health and Long-term Care (MOHLTC) of an incident where resident #029 was found having fallen with his wheelchair into the loading dock at the home on an identified date and time.

Review of the CI report revealed the resident was found by security guard from the nearby building at the identified time at the bottom of the loading dock with his/her wheelchair overturned. The security guard called 911 and notified the RN on duty. The resident was assessed by RN #120 to have sustained injuries to several parts of his/her body and was transferred to hospital. The resident returned after 24 hours and continued to receive monitoring at the home. The home had initiated an investigation of the incident.

Observation of resident #029 during the inspection period revealed the resident with no visual scars nor bruising and with no complaints of pain. The resident was not able to be interviewed related to cognitive impairment.

Resident #029's written plan of care with an identified date was reviewed. The resident ambulated in wheelchair and can propel him/herself around the unit and off floors. The resident was described as at high risk for falls. There were focus, goal and interventions set up to address the resident's risk for falls including hourly safety checks on all shifts. Review of the resident's safety check record revealed that on the day of the incident, resident was last checked for his/her where about and was toileted at 35 minutes before the incident time. Then the resident was seen by RN #120 on the ground floor and refused to go back to his/her unit when the RN tried to encourage him/her to.

During an interview, the Executive Director (ED) indicated that the home had completed the investigation of the incident. The ED reviewed the video footage of the security camera which showed the inside door from the hallway to the loading dock was always locked with a red light indicating it was locked. Staff entering the door would have to use their access swipe card to unlock the door with the light turned green. After entering the door, staff were supposed to use the swipe card to lock the door and turned the light to red before they leave the door. However on the day of the incident, video footage showed staff entering and leaving the door from an hour and a half prior to the incident, did not need to use the swipe card and they did not check to see if the light returned to red after they use the door. The resident was seen entering the door at two minutes before the incident and was found fallen into the dock at the identified incident time. The camera did not cover the dock area so how the resident fell was not able to be seen. The ED interviewed the staff identified as entering and leaving the doors at the time. Three of the four staff interviewed stated that they had noticed the door light stayed green around the time of the incident and did not report to anyone, thinking another staff would have reported it. The ED stated the home had just installed a new software for the security camera and was not able to produce a copy of the video for the inspector. The ED provided a video surveillance report to the Inspector with the sequences of events as described by the ED.

The Inspector interviewed Housekeeping Aides #103, and #145 who were on duty on the day of the incident. During the interviews, Housekeeping Aides #103 and #145 indicated that they noticed the door leading to the loading dock was not locked when they entered and exited the doors between 40 minutes prior to the incident time on the day of the incident. Both Housekeeping Aides did not report the doors were left unlocked to anyone, and both said they thought another staff would report it.

Interview with the Director of Environmental Services (DES) indicated staff were expected by the home to report malfunctioning of any doors leading to non-residential areas. Interview with the ED confirmed that the home has failed to ensure doors leading to non-residential areas were locked when they were not being supervised by staff.

The severity of this incident is actual harm as the resident sustained injury. The scope of this incident is isolated to this resident. There is one or more non-compliance in similar areas issued to the home in the last three years. Based upon this information, a compliance order is warranted. [s. 9. (1) 2.]
(512)

2. The licensee has failed to ensure that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff.

Inspection was initiated after the doors to the laundry room at the basement level were observed to be left open with no staff inside twice during the course of the inspection. The laundry room was equipped with two doors, one at both ends of the room. Drums of chemicals were observed inside the laundry room connected to the washing machines. A hair salon for residents and a resident's recreation room were located across the hallway from the laundry room.

Observation was made on an identified date and time during the inspection, revealed the doors to the laundry rooms were closed but not locked. There were no staff inside the laundry room. A resident was observed sitting in the hair salon at the time and was in clear view of the laundry room. The Inspector waited for five minutes and did not see any staff in the vicinity. An identified management staff of the home came out from the kitchen down the hallway and was approached by the Inspector. The management staff stated the laundry room doors were supposed to be locked when not supervised by staff. The management staff stated the laundry staff must have gone home by that time and proceeded to lock the laundry room doors. The management staff stated he/she will inform the Inspector's observation to the DES.

Interview with the DES confirmed the laundry room doors were to be locked when staff finished their shift. [s. 9. (1) 2.]

2. Observation made at an identified date and time during the inspection revealed the door on the housekeeping room on an identified unit was found unlocked. The following chemicals were observed in the room:

-Green Earth Daily Floor Cleaner on the wall dispenser
-Betco Fastdraw Daily Disinfectant SC on the wall dispenser
-Spray bottle of Accel TB on the floor
-Bottle of Shinner Spray Buff on the floor

An interview with Housekeeping Aide #103 confirmed that the housekeeping door should be locked at all times. An interview with RN #101 revealed that residents on the identified unit did wander around the unit.

An interview with the DES #102 stated that the housekeeping door should be kept locked when unattended to ensure that hazardous substances are kept inaccessible to residents at all times. [s. 9. (1) 2.]
(512)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 31st day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tilda Hui

Service Area Office /
Bureau régional de services : Toronto Service Area Office