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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_635600_0005	016683-16, 005486-17	Critical Incident System

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

GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 24, 27, 28, March 1, 2, and 3, 10, 13, 14, and 15, 2017.

During this inspection critical incident (CIS) reports #2754-000006-16, intake log #016683-16, and CIS #2754-000006-17, intake log #005486-17, were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing Services (DNS), Director of Resident Care (DRC), Resident and Family Services Coordinator (RFSC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed clinical records, staff education records, Critical Incident System record, and policies for falls prevention.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident and 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.

Review of the critical incident system (CIS) report submitted to the Ministry of Health and long Term Care (MOHLTC) on an identified date, revealed that a complainant had reported to the home of an alleged/incompetent treatment of the resident that resulted in harm of the resident. On a specific date, resident #004 had been transferred to hospital for identified signs to one of the extremities . Resident was admitted in the hospital with medical condition and intervention had been performed.

Review of resident #004's plan of care revealed the resident was admitted to the home on an identified date, with some medical condition. Minimum data set (MDS) record review from an identified date revealed that the resident had some cognitive decline. The resident needed extensive assistance with one staff for most of the ADLs. For one ADL the resident needed total assistance by two staff. Resident needed partial physical support during some tests and had partial loss of voluntary movement.

On a specified date, afternoon, initial progress notes revealed that registered nurse (RN) #106 documented that an area of the resident's body had significant change with some identified signs. The notes indicated that the staff had put the resident back to bed, applied an intervention and were to monitor the resident.
- Later on the same day registered practical nurse (RPN) #107 documented that the resident's identified area of the body extremity had some identified signs so he/she had called the RN #108 to assess. The RN was not able to identify the function of the resident's identified area of concern. The RPN and the RN repositioned the resident from one to another side and they noticed some improvement. The intervention provided was to monitor the resident.
- By the ends of his/her shift the RPN #107 documented that the identified area had improved but not fully.
On next identified date, early that morning RPN #104 documented that resident verbalized discomfort when he/she tried to assess the identified area of concern. The identified area had decline in condition. He/she sent the resident to the hospital and notified the SDM and the physician.

On following date, the resident underwent a specific change in his/her condition.

Interview with personal support worker (PSW) #109, revealed that in the morning of the identified date, just after breakfast when he/she provided care to resident #004, the PSW identified that the resident had changed condition when he/she assisted to the resident to the toilet. The resident expressed discomfort to identified area of the body when the PSW asked him/her what was wrong. The PSW had notified the RN #106, who came, observed the resident and told the PSW to put the resident in bed and apply some specific interventions.

Interview with RN #106 revealed that on the identified date, PSW #109 called him/her to see the resident after breakfast but because he/she had been busy with a newly set task at the time when PSW #109 notified him/her. The RN indicated that he/she went to see the resident after lunch and told the PSW to apply some intervention and to monitor the resident. The RN indicated that he/she had not communicated with the physician about the resident's condition and did not contact the substitute decision maker (SDM). The RN further indicated that the resident's change of condition was acute and he/she should have called the physician for further directions.

Interview with RPN #107 revealed that he/she monitored the resident as the day nurse endorsed, and when he/she checked the resident's identified body part later on that evening, he/she was worried about the condition of the body part and wanted to send the resident for further assessment. He/she called the RN in charge for clinical support and decision for hospitalization.

Interview with RN in charge #108 revealed that on the identified date, later that evening he/she was called by the evening RPN to see resident #004. The RN indicated that when he/she saw the resident had declined in condition. Further the RN indicated that practice in the home was when they have some acute condition, they are to contact the physician immediately. The RN stated that he/she should have called the physician for further direction when she was not able to identify the function.

Interview with DNS confirmed that the expectation of the registered staff in the home is to contact the physician for further directions when there is an acute change in residents' condition. The registered staff should have assessed the resident for discomfort and functioning and contact the physician for further instruction. The DNS also confirmed that the registered staff should contact him/her or the DRC if they were busy or needed assistance to assess resident #004.

Interview with the physician #110 revealed that this condition was very acute and surprising for everyone, including him/her who assessed the resident day before the identified date, and there was no indication for any functioning problem, especially that the resident didn't have any history of medical condition, was not taking any medication and did not experienced any signs or symptoms to be at risk for that particular medical condition. However, the physician stated, just because of the fact that this was not common for this resident, when the nurse noted change in the condition, they should have contacted him/her right away for further direction.

The scope was identified to be isolated to one resident; severity was identified to be actual harm as resident #004 underwent change in health condition. Due to the severity of actual harm to resident #004, a compliance order is warranted. [s. 6. (4) (a)]

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Review of the critical incident submitted to the MOHLTC on an identified date, revealed that resident #001, had an incident on a specific date sustained injury and was sent for further assessments and treatment. The resident returned the same day with significant change in a condition.

Interview with the director of nursing services (DNS) confirmed that the resident had incident, and was sent for further assessment and received treatment for identified injury. The DOC also confirmed that the home did not inform the MOHLTC because the incident happened on a specified day. On next working day they tried to investigate what happened and finally completed and submitted the report by the end of the week. Further the DNS confirmed that the home did not call the after hours contact number to inform the MOHLTC about the incident. [s. 107. (3)]

Issued on this 9th day of May, 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) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2017_635600_0005
Log No. / Registre no:	016683-16, 005486-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 1, 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. 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
(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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to 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.

The plan must have the following elements in place:
- ensuring that an assessment appropriate to the condition of a resident is conducted by the registered nursing staff.
- A process to ensure that registered staff communicate findings to the physician.
- A process to ensure that communication to the SDM is established and maintained.

The plan must also include interventions and a process to monitor communications between the registered staff and the leadership team for any residents identified with a significant change in health condition.

For all the above, as well as for any other elements included in the plan, please include who will be responsible for implementing, as well as a time line for achieving compliance, for each part of the plan.

The plan shall be submitted to Gordana.Krstevska@ontario.ca by May 15, 2017.

Grounds / Motifs :

1. 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 assessment of the resident and 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.

Review of the critical incident system (CIS) report submitted to the Ministry of Health and long Term Care (MOHLTC) on an identified date, revealed that a complainant had reported to the home of an alleged/incompetent treatment of the resident that resulted in harm of the resident. On a specific date, resident #004 had been transferred to hospital for identified signs to one of the extremities . Resident was admitted in the hospital with medical condition and intervention had been performed.

Review of resident #004's plan of care revealed the resident was admitted to the

home on an identified date, with some medical condition. Minimum data set (MDS) record review from an identified date revealed that the resident had some cognitive decline. The resident needed extensive assistance with one staff for most of the ADLs. For one ADL the resident needed total assistance by two staff. Resident needed partial physical support during some tests and had partial loss of voluntary movement.

On a specified date, afternoon, initial progress notes revealed that registered nurse (RN) #106 documented that an area of the resident's body had significant change with some identified signs. The notes indicated that the staff had put the resident back to bed, applied an intervention and were to monitor the resident.
- Later on the same day registered practical nurse (RPN) #107 documented that the resident's identified area of the body extremity had some identified signs so he/she had called the RN #108 to assess. The RN was not able to identify the function of the resident's identified area of concern. The RPN and the RN repositioned the resident from one to another side and they noticed some improvement. The intervention provided was to monitor the resident.
- By the ends of his/her shift the RPN #107 documented that the identified area had improved but not fully.
On next identified date, early that morning RPN #104 documented that resident verbalized discomfort when he/she tried to assess the identified area of concern. The identified area had decline in condition. He/she sent the resident to the hospital and notified the SDM and the physician.
On following date, the resident underwent a specific change in his/her condition.

Interview with personal support worker (PSW) #109, revealed that in the morning of the identified date, just after breakfast when he/she provided care to resident #004, the PSW identified that the resident had changed condition when he/she assisted to the resident to the toilet. The resident expressed discomfort to identified area of the body when the PSW asked him/her what was wrong. The PSW had notified the RN #106, who came, observed the resident and told the PSW to put the resident in bed and apply some specific interventions.

Interview with RN #106 revealed that on the identified date, PSW #109 called him/her to see the resident after breakfast but because he/she had been busy with a newly set task at the time when PSW #109 notified him/her. The RN indicated that he/she went to see the resident after lunch and told the PSW to apply some intervention and to monitor the resident. The RN indicated that he/she had not communicated with the physician about the resident's condition

and did not contact the substitute decision maker (SDM). The RN further indicated that the resident's change of condition was acute and he/she should have called the physician for further directions.

Interview with RPN #107 revealed that he/she monitored the resident as the day nurse endorsed, and when he/she checked the resident's identified body part later on that evening, he/she was worried about the condition of the body part and wanted to send the resident for further assessment. He/she called the RN in charge for clinical support and decision for hospitalization.

Interview with RN in charge #108 revealed that on the identified date, later that evening he/she was called by the evening RPN to see resident #004. The RN indicated that when he/she saw the resident had declined in condition. Further the RN indicated that practice in the home was when they have some acute condition, they are to contact the physician immediately. The RN stated that he/she should have called the physician for further direction when she was not able to identify the function.

Interview with DNS confirmed that the expectation of the registered staff in the home is to contact the physician for further directions when there is an acute change in residents' condition. The registered staff should have assessed the resident for discomfort and functioning and contact the physician for further instruction. The DNS also confirmed that the registered staff should contact him/her or the DRC if they were busy or needed assistance to assess resident #004.

Interview with the physician #110 revealed that this condition was very acute and surprising for everyone, including him/her who assessed the resident day before the identified date, and there was no indication for any functioning problem, especially that the resident didn't have any history of medical condition, was not taking any medication and did not experienced any signs or symptoms to be at risk for that particular medical condition. However, the physician stated, just because of the fact that this was not common for this resident, when the nurse noted change in the condition, they should have contacted him/her right away for further direction.

The scope was identified to be isolated to one resident; severity was identified to be actual harm as resident #004 underwent change in health condition. Due to the severity of actual harm to resident #004, a compliance order is warranted. [s.

6. (4) (a)] (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 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 1st day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gordana Krstevska

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