Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2019	2018_324535_0014 (A1)	030416-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Rekai Centres (fka Drs. Paul and John Rekai Centre)
345 Sherbourne Street TORONTO ON M5A 2S3

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

Sherbourne Place
345 Sherbourne Street TORONTO ON M5A 2S3

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

Amended by VERON ASH (535) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance due date for order #001 was amended.

Issued on this 31st day of January, 2019 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2019	2018_324535_0014 (A1)	030416-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Rekai Centres (fka Drs. Paul and John Rekai Centre)
345 Sherbourne Street TORONTO ON M5A 2S3

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

Sherbourne Place
345 Sherbourne Street TORONTO ON M5A 2S3

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

Amended by VERON ASH (535) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 16, 19, 20, 21, 22, 26, 27, 28, 29, 30, December 3, 4, 5, 6, 10, 11, 12, 14, 2018; and offsite on December 17 and 18, 2018.

The following intakes were completed concurrently with the RQI: Log #s :010996 -17 (related to physical abuse); 029221-17 (related to abuse); 010113-17 (related to abuse); 030957-18 (related to abuse).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DNS), Director of Resident Care (DRC), Registered Dietitian (RD), Director of Environmental Services (DES); Resident Care Coordinator (RCC); Behavior Support Lead (BSL); registered staff RN/ RPN; personal support worker (PSW), life enhancement worker (LEW), housekeeping staff, President of Residents' Council, Substitute Decision Makers (SDMs) and residents.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service; medication administration; staff and resident interactions; provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, meeting minutes of Residents' Council and annual evaluation of mandatory programs, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **11 WN(s)**
- **7 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During the initial tour of the home on an identified date, the inspector observed the following housekeeping concerns:

-second, third and fourth floors, black substance was observed to be in the creases of multiple residents' room door entrances; and along the length of the floor leading down the corridors.

-second, third and fourth floors appeared uncleaned with dull appearances on the tiles in the resident lounges; and along the length of the corridors. The fourth floor lounge had areas of spillage of dried, beige-brown liquid and paper debris on the floor.

-sitting areas at the end of the long corridor on the second, third and fourth floors where chairs were located for residents to sit, revealed uncleaned floors stained with dried black-brown substance on the floor under the chairs.

-black substance observed in the grooves in the metal entrance plates of both elevators on the main floor.

-dried food particles and stains from dried, brown fluid observed along the inside areas of the side rails in the corridor on the fourth floor.

-second and fourth floor Spa rooms were observed to have blackened substances inside the grout of the tiles in the shower stalls.

During separate interviews, housekeeping staff #109, #110, and #111 stated the chemicals currently being used to clean the home were not as effective at cleaning the dirt and debris on the floors and in the creases of the doorways and shower stalls. Staff verified that they had informed their supervisor of the same. Housekeeping staff #109 also verified that the floor areas under the chairs at the end of the corridor appeared uncleaned, but informed the inspector that those areas were usually cleaned by the full time housekeeping staff that was away from the home for an extended period. Housekeeping staff #110 stated the level of staffing who work in housekeeping was lessened by the home over the past years; and that they also observed a difference in the appearance and cleanliness of the home.

During a walk about interview with the inspector, the Director of Environmental

Services (DES) verified that the areas listed above were not cleaned; and that those areas were required to be cleaned by the assigned housekeeping staff. The DES verified that the full time housekeeping staff was away for an extended period; but stated that temporary full time and part time workers received the same training and should be able to provide the same level of service. The DES also stated that they do not require staff to sign off when work was completed because they believed that to be demoralizing to the staff; and that a signature was not proof that the work was being completed. According to the DES, housekeeping audits were completed by various management staff in the home on a regular basis.

During an interview, the Executive Director (ED) stated that the cleanliness of the home was raised by family members during their last Quarterly Family Information Meeting held by the home. The ED also verified that the DES was present during the meeting; that the staffing level was adjusted years ago; and that the chemical products being used in the home may have been changed a few years ago with the addition of a new vendor added to the home's chemical vendors list. The ED stated that the home was aging, and that they were focusing on the maintenance of the main floor of the home; but that a preventative maintenance program was in place to support the upkeep of the floors in all areas of the home. [s. 15. (2) (a)] (535)

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

During the initial tour of the home on an identified date, the inspector observed the following areas of disrepair in the home:

-second floor heating unit in the residents' lounge was non-functional and covered with a thick blanket. During an interview, registered staff #113 verified that often the heating unit does not work leaving the room cold when the temperature was low outside.

-third floor heating unit in the residents' lounge had a thin sheet of aluminum type metal added to cover over the top of the unit. The metal covering had sharp edges exposed along the full length. The home's Life Enrichment Worker (LEW) #108 acknowledged that the aluminum type metal had sharp edges; but also stated that residents usually do not go over to the heater by the window.

-fourth floor, there were three brown leatherette covered, single seated chairs in the residents' lounge. The arm rest areas of all three chairs had multiple cuts on the arms which causes the white stuffing inside the leatherette to be exposed. And, one chair had multiple cuts on the seating area with white stuffing exposed.

-second, third, and fourth floor Spa rooms were observed to have multiple areas of disrepair with drywall exposure. During an interview, the DES stated the third floor Spa room was in its original state since the home was built; and verified that the building was 30 years old. The DES also stated unlike the second and fourth floors Spa rooms, the third floor Spa room was not yet renovated.

-second, third and fourth floors, there were multiple areas of disrepair observed on the baseboards along the corridors. During an interview, the DES acknowledged that the baseboards require repainting.

On another identified date, during stage one of the Resident Quality Inspection (RQI), the inspectors observed the following disrepair:

-fourth floor in three residents' identified rooms - two holes in the wall in the residents' washroom with dry wall exposed; a large area on the wall with brownish-beige stains behind the resident's bed; and wall disrepair with drywall exposure; and the toilet tank cover was missing in the washroom and the tank was left opened.

-third floor in two identified residents' rooms - multiple areas of disrepair on the walls with dry wall exposure.

-second floor in one identified resident room - scratches observed on the wall with drywall exposure; as well, the light in the room kept flashing on and off. During an interview, the DES verified that they had changed the Ballast and the bulb in the room to resolve the issue related to the flashing light.

During an interview, the DES also verified the state of disrepair listed in all areas above; informed the inspector that they removed the arm chair with both arms and seating area cut open with the white stuffing exposed; and that they were planning maintenance repair to the home when the maintenance worker returned from emergency leave in one to two weeks. Upon request, the DES verified that they did not have a preventative maintenance plan prepared and available for review.

During an interview, the home's ED verified that all staff should be entering information related to the home's state of disrepair into the Maintenance Care electronic program so that maintenance staff could resolve those issues; and the DES should follow up to ensure the work gets completed. The ED also stated that there should have been a preventative maintenance plan created and being implemented to ensure resident's rooms, the corridors and other areas in the home were maintained in a good state of repair. [s. 15. (2) (c)] (535)

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: 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 resident #033 was protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act physical abuse means the use of physical force by a resident that causes physical injury to

another resident.

The Ministry of Health (MOH) received a critical incident on an identified date related to resident #034's responsive behavior which caused resident #033 to sustain an injury.

Record review indicated resident #033 was assessed using the home's quarterly Minimum Data Set (MDS) assessment tool on an identified date.

Another record review indicated that resident #034 was also assessed using the home's quarterly MDS assessment tool on an identified date.

A review of the critical incident and interview with registered staff RN #132 verified that on an identified date and time, resident #034 entered a resident area where resident #033 and a family member was visiting. Resident #034 made a remark to resident #033 as they entered the room; and a verbal altercation started between the two residents. During the incident, resident #034 directed and moved their wheelchair towards resident #033. Their wheelchair struck the resident on an identified area of the body which caused an injury.

During the interview, RN #132 stated they did not actually witness the incident at the beginning; but verified that they separated both residents and applied first aid treatment to support resident #033's injury; and verified that the police attended the home.

During an interview, the Resident Care Coordinator (RCC) #132 stated resident #034 was a very spiritual person. They believed multiple verbal altercations started between the two residents after resident #033 informed resident #034 of their personal health information. RCC #132 verified that resident #034 had strong spiritual beliefs and thoughts regarding the topic of discussion; and became set in their mind negatively against people with that personal health history.

During separate interviews, PSW #135, RN #100, RN #132, DON #102, and Behavior Support lead (BSL) RPN #128 verified that resident #033 and #034 engaged in multiple verbal altercations prior to the reported physical altercation. RN #100 verified that resident #034 was transferred to another unit as a result of these conflicts; and that multiple other strategies were put in place by the home to avoid further altercations between both residents.

DON #102 verified during an interview that they were not aware of the initial verbal altercations between both residents because in the past they had seen both residents sitting and talking together on the unit. However, since resident #033 disclosed their health information to resident #034; that started multiple episodes of altercations which escalated to the physical altercation. Furthermore, the DON acknowledged the incident to be physical abuse and investigated and reported the incident to the Director under s. 19. [s. 19. (1)] (535)

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan of care.

During the RQI, resident #010 triggered for hospitalization and change in condition.

The resident was assessed using the annual MDS assessment tool on an identified date.

Record review of the progress notes indicated that on an identified date, PSW #131 removed the resident's clothing, and then walked over to the windowsill to get the replacement clothing, when the resident suddenly reached forward and fell from the wheelchair onto the floor.

During an interview, PSW #131 verified that they attempted to change the resident's clothing while they were still sitting in their wheelchair. However, the PSW stated they mistakenly removed the external device from the wheelchair before walking over to the windowsill to get the clean clothing; and the resident suddenly reached forward. The PSW stated the incident happened very quickly; and although they tried to stop the resident from falling, they could not get there fast enough. The resident subsequently fell out of the wheelchair onto the floor and sustained an injury to an identified area of the body.

Record review of the resident's plan of care indicated the resident was to use an external device while sitting in the wheelchair for the prevention of falls and injury. During an interview, PSW #131 verified they removed the device while the resident was stil sitting in the wheelchair, which allowed the resident to fall and sustain the injury. They stated that they should have kept the device in place while the resident was still sitting in the wheelchair.

During an interview, the home's Director of Nursing verified that the PSW did not follow the plan as specified in the plan of care when they removed the device and walked away from the resident. The DON further stated the PSW should have kept the device in place while changing the resident's clothing; and verified that they discussed the incident in their recent staff meeting; and that PSWs should have equipment and supplies available at the bedside prior to initiating personal care activities. [s. 6. (7)] (535)

Additional Required Actions:

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

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 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system in place, the plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with r. 30 (2), the licensee was required to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Specifically, staff did not comply with the licensee's policy, "Skin Care and Wound Management Program", last revised August 2016. The wound assessment documentation section of the policy indicated that registered staff need to make sure that the location of wound (foot, leg, thigh, elbow, etc.) was incorporated in

their wound assessment documentation.

Resident #001 was triggered from stage one for presence of an altered skin integrity through census review.

A record review of resident #001's progress notes in point click care (PCC) indicated that the resident had three areas of altered skin integrity on three separate areas of the body. Review of the weekly skin and wound assessments in PCC indicated assessments were done for the first identified altered skin integrity on multiple dates. The weekly skin and wound assessments for an identified altered skin integrity area did not identify the location on the assessment.

2. Resident #007 was triggered from stage one for a new/worse altered skin integrity through census review.

Resident #007 was admitted to the home on an identified date. A record review of resident #007's head to toe skin assessment on an identified date, indicated the resident had two separate identified areas of altered skin integrity.

A review of resident #007's weekly skin and wound assessments in PCC for multiple identified dates indicated that the location of the altered skin integrity was not documented.

In separate interviews, RN #100 and RPN #114 stated that it was the home's policy for the location of all altered skin integrity to be documented in the weekly skin and wound assessments. The registered staff reviewed the skin and wound assessments in PCC for residents #001 and #007; and verified that the location of both altered skin integrity were not documented.

In an interview, Skin and Wound Lead (SWL) #136 verified it was the home's policy for the location of any altered skin integrity to be documented in the weekly skin and wound assessment. The SWL stated it was important for the location of each altered skin integrity be documented in the weekly assessment so that each area can be monitored for healing progression. The SWL reviewed residents #001 and #007's skin and wound assessments in PCC, and acknowledged that the registered staff did not document the location of the altered skin integrity on resident #007's weekly skin and wound assessments as per home's policy. [s. 8. (1) (a),s. 8. (1) (b)] (665)

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 required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system in place, the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure without in any way restricting the generality of the duty provided for in section 19, that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

An interview with the complainant and a review of the complaint received by Ministry of Health and Long-term care (MOHLTC) on an identified date, indicated that resident #023 reported that an incident occurred with a staff in the home on an identified date.

During an interview with resident #023, they verified the incident did occur and

added that they were adjusting to the new environment in the home. The resident made an allegation of abuse and identified the staff involved in the incident. They also stated that they reported the incident to Life Enrichment Worker #108; and other people in the home.

During an interview, Life Enrichment Worker (LEW) #108 stated that they remembered the resident reported a similar incident; however, it was a long time ago; they did not document the incident; and they did not report the incident to the DON. The LEW verified that the incident should have been reported to the DON; however, they did not report the incident.

A review of the home's policy #P-10, entitled, "Abuse or Neglect Policy", revised August 10, 2017, indicated that on becoming aware of abuse or neglect, suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Director at the MOHLTC, the Administrator or if not available, the Director of Nursing or delegate.

During interviews, DRS #103 and DON #102 stated that the resident was still trying to adjust to the new home environment. They were aware that the resident had identified responsive behaviors, and spoke with staff about the resident's behaviors. However, they were not aware that the resident had reported an incident of abuse by the staff. DNS #102 stated that they could not recall submitting a critical incident or conducting an investigation related to an allegation of abuse reported by the resident; however as per the home's abuse policy, the allegation of abuse should have been reported to the MOHLTC and investigated by the home. The DON further verified that staff should immediately report all suspected or alleged incident of abuse. [s. 20. (1)] (500)

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 without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During a review of the home's skin and wound management program, the inspector requested the home's 2017, annual evaluation of the program. The Director of Nursing Services (DNS) #102 was not able to provide documentation of the evaluation.

In an interview, Skin and Wound Lead #136 stated that they had completed the 2017 annual evaluation of the program but was unable to locate the evaluation.

In an interview, DNS #102 verified that the skin and wound program annual evaluation for 2017 was completed; however, the home was unable to locate the evaluation. The DNS acknowledged that the home had failed to ensure that the written documentation of the annual evaluation was kept. [s. 30. (1) 4.] (665)

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 a written record is kept relating to each evaluation under paragraph 3 that include the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes are implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #001 was triggered from stage one for the presence of altered skin integrity through census review.

A record review of resident #001's progress notes in point click care (PCC) indicated that the resident had three separate altered skin integrity on three identified areas of the body.

A review of the electronic treatment administration record (eTAR) on an identified date, and the progress notes indicated that treatments to the three areas were initiated on three separate identified dates.

Review of the weekly skin and wound assessments in PCC indicated assessments were not completed for one identified altered skin integrity area during multiple dates. The weekly skin and wound assessments for another identified altered skin integrity did not identify the location of the area assessed. Further review of the weekly skin and wound assessments did not locate

documentation of a weekly skin and wound assessments related to the third location of altered skin integrity. [s. 50. (2) (b) (iv)] (665)

2. Resident #007 was triggered from stage one for a new/worse altered skin integrity through census review.

Resident #007 was admitted to the home on an identified date. Record review of resident #007's assessment on an identified date, indicated the resident had two areas of altered skin integrity located on identified areas of the body.

A review of resident #007's electronic treatment administration records (eTARs) for an identified period indicated the scheduled dates when assessments related to the two areas were to be completed. A review of the weekly skin and wound assessments in PCC indicated the weekly assessments were not completed as per the eTAR schedule for both identified altered skin integrity area on identified dates.

In interviews, RN #100 and RPN #114 stated that it was the home's process for weekly skin and wound assessments to be completed separately for each altered skin integrity concern. The RN and RPN stated that it was important that weekly skin and wound assessments were completed to monitor the status of each area, and assess the need for alternate treatment or referrals. The registered staff RN reviewed the skin and wound assessments in PCC related to resident #001 and #007, and verified that both residents weekly skin and wound assessments were not completed consistently related to their altered skin integrity.

In an interview, Skin and Wound Lead (SWL) #136 stated it was the home's process for weekly skin and wound assessments to be completed separately related to each altered skin integrity concern. The SWL also stated it was important for the weekly skin and wound assessments to be completed to ensure monitoring of the progress of each altered skin integrity area; and to facilitate changes in the treatment plan and support required referrals. The SWL reviewed resident #001 and #007's weekly skin and wound assessments in PCC, and acknowledged that the registered staff did not consistently complete the weekly skin and wound assessments related to both residents altered skin integrity. [s. 50. (2) (b) (iv)] (665)

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behavior program was being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

Inspector reviewed the home's system for annually evaluating the responsive behavior program. The documents indicated that the home does an audit of the responsive behavior program annually; however, the audit does not meet the Ministry of Health and Long Term Care Legislative requirements under this section.

During an interview, DNS #102 acknowledged that the home did not complete an annual evaluation of the responsive behavior program. [s. 53. (3) (b)] (652)

2. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviors included, assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

An identified critical incident system (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, related to resident to resident physical abuse.

Record review of resident #043's electronic progress notes in point click care (PCC) on an identified date, indicated that a personal support worker reported to the registered staff that they heard resident #044 saying if resident #043 did not stop talking they would harm resident #043. The progress notes indicated that the PSW saw resident #044 and resident #043 engaged in a physical altercation. The PSW intervened and was able to stop the altercation. Neither residents sustained an injury as a result of the altercation.

Record review of resident #044's progress notes indicated there was a history of altercations between the two residents. A previously dated progress note indicated resident #044 reported to the personal support worker that resident #043 had previously engaged them in another altercation which caused an injury. A progress note on that same date indicated that resident #044 was assessed after the incident; and they had an altered skin integrity.

Record review of the critical incident and progress notes for resident #043 and #044 indicated although both residents had responsive behaviors, there was no evidence to support that a responsive behavior risk assessment had been completed for both residents prior to the date of the identified critical incident. Record review of resident #044's healthcare records indicated that there was a report from an identified source on an identified date, which directed resident #044 to avoid contact with resident #043.

Interview with RN#127 acknowledged that both residents did not have a responsive behavior assessment completed prior to both altercations.

Interviews with DRC #103 and DNS #102 acknowledged that a responsive behavior assessment should have been completed for resident #043 and resident #044 when both residents engaged in physical altercations; and when they both reported the incidences above to the registered staff. [s. 53. (4) (c)] (652)

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 responsive behavior program is being evaluated annually and updated in accordance with evidence-based practices or prevailing practices; and,
-to ensure that the actions taken to meet the needs of the resident with responsive behaviors include assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared.

Record review of the home's 2017 annual abuse and neglect program evaluation documents provided by the home's DNS, included a summary of all critical incidents completed by the home within the electronic risk management system on a monthly basis from January to December 2017. The risk management document also indicated incidents related to abuse; however there was no analysis of the abuse incidents on a monthly or quarterly basis included in the document. Also, the summary document was titled '2017 CIS Trend Action Plan', and not an annual evaluation of the abuse and neglect program as requested.

During an interview, DNS #102 informed the inspector that they were not able to locate the home's 2017 annual abuse and neglect evaluation because the written records were misplaced. The DNS acknowledged their awareness that the annual abuse and neglect program evaluation was to be completed; and that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of resident should be retained by the home. [s. 99. (e)] (535)

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 a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements are implemented, is promptly prepared, to be implemented voluntarily.

WN #10: 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. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written record of the annual infection prevention and control program evaluation was kept that included a summary of the changes made and the date that those changes were implemented.

Record review of the home's 2017 annual infection prevention and control program evaluation outlined the home's expected outcomes. The action plan did not have documentation to indicate if changes were made; and the dates those changes were implemented.

In an interview, IPAC Lead #103 stated that they did not complete documentation of the home's 2017 annual evaluation of the infection prevention and control program.

In an interview, DNS #102 verified that documentation should have been

completed and retained related to the home's annual evaluation of the infection prevention and control program. The DNS acknowledged that the home did not follow legislative requirements related to documentation of the summary of changes made related to the program; and did not include the date any changes were implemented to the annual evaluation of the infection prevention and control program. [s. 229. (2) (e)] (665)

2. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

During stage one of the RQI, observations conducted in shared residents' washrooms indicated the following:

-On an identified date and time, in an identified shared washroom – white urine collection hat was observed lodged between the wall and the toilet tank.

-On an identified date and time, in another identified shared washroom – two urine collection hats were observed on top of the toilet tank. One of the two urine collection hats were unlabelled as to which resident it belonged to.

In interviews, PSW #119 stated the urine collection hats were not to be lodged between the wall and the toilet tank; and stated they were to be stored on the floor in the resident washroom. PSW #106 stated urine collection hats were to be labelled with the resident's name and stored against the resident's towel bar in the washroom. RN #100 stated the urine collection hats were to be stored on top of the toilet tank in the residents' room. When both staff were asked what was the home's policy regarding storage of the urine collection hats, they all indicated they were not sure what was written in the home's policy.

In an interview, IPAC Lead and DRC #103 stated that urine collection hats were to be labelled with the resident's name; stored in the resident's bedside drawer; and discarded after use related to infection prevention and control. The IPAC Lead verified the urine collection hats were not to be left unlabelled in a shared washroom. The IPAC Lead acknowledged that staff did not participate in the implementation of the home's infection prevention and control program. [s. 229. (4)] (665)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that the written record of the annual infection prevention and control program evaluation is kept that includes a summary of the changes made and the date that those changes are implemented; and, -to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure there was a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

The nutrition and hydration inspection protocol (IP) was inspector-initiated for resident #013 as a result of missing recorded height. During stage one of the Resident Quality Inspection (RQI), census review on an identified date, and staff interview on another identified date, indicated the last documented height for resident #013 was in June 2017. [s. 68. (2) (e) (ii)] (665)

2. The nutrition and hydration inspection protocol (IP) was inspector-initiated for resident #012 as a result of missing recorded height. During stage one of the RQI, census review on an identified date, and staff interview on another identified date, indicated the last documented height for the resident was in October 2017. [s. 68. (2) (e) (ii)] (665)

3. The nutrition and hydration inspection protocol (IP) was inspector-initiated for resident #002 as a result of missing recorded height. During stage one of the RQI, census review on an identified date, and staff interview on another identified date, indicated the last documented height for the resident was in May 2017.

In an interview during stage one of the RQI on an identified date, RN #100 verified the home's process related to resident heights which was to be taken on admission and on an annual basis in January of each year. RN #100 stated residents' heights were documented on a paper worksheet; and then recorded electronically in PCC. The RN and inspector reviewed the 2018 annual height worksheets.The review of the worksheet and the documented heights in PCC indicated that resident #002, #012 and #013 did not have their annual height measured in January 2018. RN #100 indicated that the home's process was not followed regarding annual heights for resident #002, #012 and #013. [s. 68. (2) (e) (ii)] (665)

Issued on this 31st day of January, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by VERON ASH (535) - (A1)
Inspection No. / No de l'inspection :	2018_324535_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	030416-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 31, 2019(A1)
Licensee / Titulaire de permis :	The Rekai Centres (fka Drs. Paul and John Rekai Centre) 345 Sherbourne Street, TORONTO, ON, M5A-2S3
LTC Home / Foyer de SLD :	Sherbourne Place 345 Sherbourne Street, TORONTO, ON, M5A-2S3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Colette Cameron

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To The Rekai Centres (fka 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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 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. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a compliance plan outlining
how the licensee will ensure that, the home, furnishings and equipment are kept clean and sanitary; and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The compliance plan shall include but is not limited to:

1. Provide additional training to housekeeping and maintenance staff to ensure understanding of their role and responsibilities so that the home, furnishings and equipment are kept clean and sanitary; and are maintained in a safe condition and in a good state of repair. Maintain a documented record of the training, who attended, who provided the training, the content of the training and the date the training was provided.
2. Develop, implement and document a plan to ensure staff awareness and use of the home's Maintenance Care System for reporting unclean, unsafe and disrepair furnishing, flooring, and equipment in the home.
5. Develop, implement and keep a documented record of a preventative maintenance plan to ensure heating equipment in all areas of the home are kept safe and functional; spa rooms, residents' rooms and the corridors are kept clean, sanitary and in a good state of repair.
6. Communicate the plan, implementation and completion of the plan, to the home's Residents' Council and Family Information Night meetings.

For the above, as well as for any other elements included in the plan, please include who will be responsible, as well as a timeline for achieving compliance,
for each objective/goal listed in the plan.

The plan shall be submitted to the Long Term Care Home Inspector:
Veron Ash by Friday, February 8, 2019 via email to:
TorontoSAO.moh@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During the initial tour of the home on an identified date, the inspector observed the following housekeeping concerns:

-second, third and fourth floors, black substance was observed to be in the creases of multiple residents' room door entrances; and along the length of the floor leading down the corridors.

-second, third and fourth floors appeared uncleaned with dull appearances on the tiles in the resident lounges; and along the length of the corridors. The fourth floor lounge had areas of spillage of dried, beige-brown liquid and paper debris on the floor.

-sitting areas at the end of the long corridor on the second, third and fourth floors where chairs were located for residents to sit, revealed uncleaned floors stained with dried black-brown substance on the floor under the chairs.

-black substance observed in the grooves in the metal entrance plates of both elevators on the main floor.

-dried food particles and stains from dried, brown fluid observed along the inside areas of the side rails in the corridor on the fourth floor.

-second and fourth floor Spa rooms were observed to have blackened substances inside the grout of the tiles in the shower stalls.

During separate interviews, housekeeping staff #109, #110, and #111 stated the chemicals currently being used to clean the home were not as effective at cleaning the dirt and debris on the floors and in the creases of the doorways and shower stalls. Staff verified that they had informed their supervisor of the same. Housekeeping staff #109 also verified that the floor areas under the chairs at the end of the corridor appeared uncleaned, but informed the inspector that those areas were usually cleaned by the full time housekeeping staff that was away from the home for an extended period. Housekeeping staff #110 stated the level of staffing who work in housekeeping was lessened by the home over the past years; and that they also observed a difference in the appearance and cleanliness of the home.

During a walk about interview with the inspector, the Director of Environmental

Services (DES) verified that the areas listed above were not cleaned; and that those areas were required to be cleaned by the assigned housekeeping staff. The DES verified that the full time housekeeping staff was away for an extended period; but stated that temporary full time and part time workers received the same training and should be able to provide the same level of service. The DES also stated that they do not require staff to sign off when work was completed because they believed that to be demoralizing to the staff; and that a signature was not proof that the work was being completed. According to the DES, housekeeping audits were completed by various management staff in the home on a regular basis.

During an interview, the Executive Director (ED) stated that the cleanliness of the home was raised by family members during their last Quarterly Family Information Meeting held by the home. The ED also verified that the DES was present during the meeting; that the staffing level was adjusted years ago; and that the chemical products being used in the home may have been changed a few years ago with the addition of a new vendor added to the home's chemical vendors list. The ED stated that the home was aging, and that they were focusing on the maintenance of the main floor of the home; but that a preventative maintenance program was in place to support the upkeep of the floors in all areas of the home. [s. 15. (2) (a)] (535) (535)

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

During the initial tour of the home on an identified date, the inspector observed the following areas of disrepair in the home:

-second floor heating unit in the residents' lounge was non-functional and covered with a thick blanket. During an interview, registered staff #113 verified that often the heating unit does not work leaving the room cold when the temperature was low outside.

-third floor heating unit in the residents' lounge had a thin sheet of aluminum type metal added to cover over the top of the unit. The metal covering had sharp edges exposed along the full length. The home's Life Enrichment Worker (LEW) #108 acknowledged that the aluminum type metal had sharp edges; but also stated that residents usually do not go over to the heater by the window.

-fourth floor, there were three brown leatherette covered, single seated chairs in the

residents' lounge. The arm rest areas of all three chairs had multiple cuts on the arms which causes the white stuffing inside the leatherette to be exposed. And, one chair had multiple cuts on the seating area with white stuffing exposed.

-second, third, and fourth floor Spa rooms were observed to have multiple areas of disrepair with drywall exposure. During an interview, the DES stated the third floor Spa room was in its original state since the home was built; and verified that the building was 30 years old. The DES also stated unlike the second and fourth floors Spa rooms, the third floor Spa room was not yet renovated.

-second, third and fourth floors, there were multiple areas of disrepair observed on the baseboards along the corridors. During an interview, the DES acknowledged that the baseboards require repainting.

On another identified date, during stage one of the Resident Quality Inspection (RQI), the inspectors observed the following disrepair:

-fourth floor in three residents' identified rooms - two holes in the wall in the residents' washroom with dry wall exposed; a large area on the wall with brownish-beige stains behind the resident's bed; and wall disrepair with drywall exposure; and the toilet tank cover was missing in the washroom and the tank was left opened.

-third floor in two identified residents' rooms - multiple areas of disrepair on the walls with dry wall exposure.

-second floor in one identified resident room - scratches observed on the wall with drywall exposure; as well, the light in the room kept flashing on and off. During an interview, the DES verified that they had changed the Ballast and the bulb in the room to resolve the issue related to the flashing light.

During an interview, the DES also verified the state of disrepair listed in all areas above; informed the inspector that they removed the arm chair with both arms and seating area cut open with the white stuffing exposed; and that they were planning maintenance repair to the home when the maintenance worker returned from emergency leave in one to two weeks. Upon request, the DES verified that they did not have a preventative maintenance plan prepared and available for review.

During an interview, the home's ED verified that all staff should be entering information related to the home's state of disrepair into the Maintenance Care electronic program so that maintenance staff could resolve those issues; and the DES should follow up to ensure the work gets completed. The ED also stated that there should have been a preventative maintenance plan created and being implemented to ensure resident's rooms, the corridors and other areas in the home were maintained in a good state of repair. [s. 15. (2) (c)] (535)

The severity of this issue was determined to be a level 2 as there was minimum harm or potential for actual harm to residents. The scope of the issue was a level three as the issues were related to three of three resident units in the home. The compliance history indicates one or more related non compliance in the last 36 months. Therefore, due to widespread concerns related to housekeeping and maintenance issues throughout the home, a compliance order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019(A1)

Order # / Ordre no : 002

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

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 must be compliant with s. 19. (1) of the LTCHA, 2007.

Specifically, the licensee must ensure resident #033 is protected from physical abuse by anyone by completing the following:

1. Develop, document, communicate, and implement protective strategies to ensure resident #033 and #034 do not access the same areas of the home at the same time, and while unsupervised.

Grounds / Motifs :

1. The licensee has failed to ensure resident #033 was protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act physical abuse means the use of physical force by a resident that causes physical injury to another resident.

The Ministry of Health (MOH) received a critical incident on an identified date related to resident #034's responsive behavior which caused resident #033 to sustain an injury.

Record review indicated resident #033 was assessed using the home's quarterly Minimum Data Set (MDS) assessment tool on an identified date.

Another record review indicated that resident #034 was also assessed using the

home's quarterly MDS assessment tool on an identified date.

A review of the critical incident and interview with registered staff RN #132 verified that on an identified date and time, resident #034 entered a resident area where resident #033 and a family member was visiting. Resident #034 made a remark to resident #033 as they entered the room; and a verbal altercation started between the two residents. During the incident, resident #034 directed and moved their wheelchair towards resident #033. Their wheelchair struck the resident on an identified area of the body which caused an injury.

During the interview, RN #132 stated they did not actually witness the incident at the beginning; but verified that they separated both residents and applied first aid treatment to support resident #033's injury; and verified that the police attended the home.

During an interview, the Resident Care Coordinator (RCC) #132 stated resident #034 was a very spiritual person. They believed multiple verbal altercations started between the two residents after resident #033 informed resident #034 of their personal health information. RCC #132 verified that resident #034 had strong spiritual beliefs and thoughts regarding the topic of discussion; and became set in their mind negatively against people with that personal health history.

During separate interviews, PSW #135, RN #100, RN #132, DON #102, and Behavior Support lead (BSL) RPN #128 verified that resident #033 and #034 engaged in multiple verbal altercations prior to the reported physical altercation. RN #100 verified that resident #034 was transferred to another unit as a result of these conflicts; and that multiple other strategies were put in place by the home to avoid further altercations between both residents.

DON #102 verified during an interview that they were not aware of the initial verbal altercations between both residents because in the past they had seen both residents sitting and talking together on the unit. However, since resident #033 disclosed their health information to resident #034; that started multiple episodes of altercations which escalated to the physical altercation. Furthermore, the DON acknowledged the incident to be physical abuse and investigated and reported the incident to the Director under s. 19. [s. 19. (1)] (535)

The severity of this issue was determined to be a level 3 as there was actual harm to resident #033. The scope of the issue was a level one as only one resident was affected. The level 4 history of on-going non-compliance with this section of the Act that included:
Voluntary plan of correction (VPC) issued April 20, 2017 (2017_370649_0009)
Compliance Order (CO) issued January 31, 2017 (2016_251512_0016)
Therefore, due to actual harm of the resident and the home's compliance history, a compliance order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee must ensure the care set out in the plan of care is provided to the resident as specified in the plan by completing the following:

Provide additional education and/or training to PSW #131, and any other PSW who provides care to resident #010, on the resident's plan of care as it relates to consistent use of safety devices to prevent falls and/or injury.

Management and supervisor to monitor and document by random audits, personal care provided to resident #010 by PSW #131 for a reasonable time period.

Ensure the same strategies are applied to all applicable residents with heightened safety requirements in the home.

Grounds / Motifs :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan of care.

During the RQI, resident #010 triggered for hospitalization and change in condition. The resident was assessed using the annual MDS assessment tool on an identified date.

Record review of the progress notes indicated that on an identified date, PSW #131

removed the resident's clothing, and then walked over to the windowsill to get the replacement clothing, when the resident suddenly reached forward and fell from the wheelchair onto the floor.

During an interview, PSW #131 verified that they attempted to change the resident's clothing while they were still sitting in their wheelchair. However, the PSW stated they mistakenly removed the external device from the wheelchair before walking over to the windowsill to get the clean clothing; and the resident suddenly reached forward. The PSW stated the incident happened very quickly; and although they tried to stop the resident from falling, they could not get there fast enough. The resident subsequently fell out of the wheelchair onto the floor and sustained an injury to an identified area of the body.

Record review of the resident's plan of care indicated the resident was to use an external device while sitting in the wheelchair for the prevention of falls and injury. During an interview, PSW #131 verified they removed the device while the resident was stil sitting in the wheelchair, which allowed the resident to fall and sustain the injury. They stated that they should have kept the device in place while the resident was still sitting in the wheelchair.

During an interview, the home's Director of Nursing verified that the PSW did not follow the plan as specified in the plan of care when they removed the device and walked away from the resident. The DON further stated the PSW should have kept the device in place while changing the resident's clothing; and verified that they discussed the incident in their recent staff meeting; and that PSWs should have equipment and supplies available at the bedside prior to initiating personal care activities. [s. 6. (7)] (535)

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level one as only one resident was affected. The level 4 history of on-going non-compliance with this section of the Act that included:
Voluntary plan of correction (VPC) issued October 5, 2017 (2017_378116_0013)
Therefore, due to actual harm of the resident and the home's compliance history, a compliance order is warranted. (535)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 28, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by VERON ASH (535) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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