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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2019	2019_808535_0008	007560-18, 008916-18, 014052-18, 021646-18, 021683-18, 029065-18, 002589-19, 002590-19, 002591-19, 003125-19	Critical Incident System

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

VERON ASH (535), AMY GEAUVREAU (642), LISA MOORE (613)

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): May 13, 14, 15, 16, 17, 2019.

The following intakes were completed during this inspection: Logs: #007560-18, #008916-18 and #021646-18 (related to missing resident); #021683-18 (related to falls); #014052-18 (related to falls); #003125-19 (related to abuse); #029065-18 (related to neglect); #002591-19, #002589-19 and #002590-19 (related to follow up compliance order).

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), Director of Environmental Services (DES), Behavior Support Lead (BSL), registered nurses (RN), registered practical nurse (RPN), personal support workers (PSWs), housekeeping staff, maintenance staff, receptionist and residents.

During the course of the inspection, the inspector made observations related to staff to resident interactions and provision of care; conducted reviews of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2018_324535_0014	535
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2018_324535_0014	535
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2018_324535_0014	535

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible, of the circumstance of resident #001, who was missing for three hours or more.

Inspector #613 reviewed a critical incident system report submitted to the Director on an identified date, which indicated that resident #001 had exited the building on an identified date in the evening, without informing the staff, and returned on their own the next day.

A review of the home's policy, at the time of the incident, titled, "Code Yellow-Missing Resident" last revised on June 2017, indicated that the Director of Nursing Services (DNS)/Executive Director (ED)/Designate was to complete a critical incident report and have it submitted to the Ministry of Health and Long-Term Care (MOHLTC) using the Mandatory Critical Incident System (MCIS). The following were the reporting timelines and related considerations: Immediately when a resident was missing for three (3) hours or more.

During an interview with RPN #108, they stated that registered nurses do not contact the Ministry's after hours emergency contact to report critical incidents that occur after business hours. The RPN stated that management was responsible.

During an interview with the Director of Nursing Services (DNS), they confirmed that they were responsible for notifying the Director and that the Director was not immediately notified. [s. 107. (1) 3.]

Issued on this 23rd day of May, 2019

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

Original report signed by the inspector.