Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 03, 2020	2020_767643_0024 (A1)	004445-20, 022267-20	Critical Incident System

Licensee/Titulaire de permis

The Rekai Centres
160 Wellesley Street East Toronto ON M4Y 1J2

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 ADAM DICKEY (643) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This Licensee report was amended to include sources of evidence to support WN #1.

Issued on this 3 rd day of December, 2020 (A1)

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

Original report signed by the inspector.

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

Amended by ADAM DICKEY (643) - (A1)

Amended 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): November 23-26, 2020.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

Log #004445-20; CIS #2754-000005-20 - related to falls prevention and management, and

Log #022267-20; CIS #2754-000012-20 - related to emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Nursing Services (DON), the Director of Resident Care, Behaviour Support Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, recordings of voice messages on the home's telecommunications service and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

1 WN(s)
1 VPC(s)
0 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that one resident was protected from emotional abuse by staff.

Section 2. (1) of Ontario Regulation 79/10 defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Review of the resident's health records showed they had impaired cognition, a history of responsive behaviours with interventions in place to minimize the triggers to the behaviours. A Critical Incident System (CIS) report was submitted to the Director which documented suspected emotional abuse of the resident by staff members. The ED indicated recordings captured a verbal exchange between the resident and staff members. The recordings showed staff members used insulting, infantilizing language toward the resident and laughing during the exchange. The home's investigation notes and letters of discipline showed a PSW and other staff acknowledged the exchange and indicated they should have handled the situation differently. The home's investigation determined the actions of the PSW and other staff constituted emotional abuse of the resident. The DON indicated staff members responded in an abusive manner to the resident and should have re-directed the resident to de-escalate the situation. The resident became increasingly agitated by the exchange and experienced minimal harm as a result.

Sources: CIS report, resident health records, care plan, audio recordings, the home's investigation notes and letters of discipline, interviews with the DON and other staff members. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 3 rd day of December, 2020 (A1)

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

Original report signed by the inspector.