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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 2021	2021_654618_0002	024355-20, 004985-21	Complaint

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

CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 5, 14, 16 and May 28, 2021.

Complaint intakes #024355-20, and 004985-21, both related to Admissions and Discharge, were inspected during this off-site inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator of Wellesley Central Place (staff #101), the Administrator of Sherbourne Place, the Chief Executive Officer of the Rekai Centres (staff #103), and the Ontario Health Director, Health System Flow & Capacity #102.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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 O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that they maintained contact with resident #002 or their health care provider, during resident #002's medical absence in order to determine when the resident will be returning to the Home.

Resident #002 was transferred to the hospital for treatment on an identified date in 2020, and subsequently transferred to another health care provider as the Home was unable to accept the resident's return due to a COVID-19 outbreak.

When the outbreak resolved Ontario Health and facility where resident #002 was transferred to agreed to keep the resident while parties pursued alternative arrangements for the resident's housing and care needs. Suitable arrangements were found, but the resident declined to accept the move, and the process of finding them alternate living arrangements or returning to Sherbourne Place did not continue.

Information provided by the Home did not identify dates when they communicated with the resident to discuss their return to the Home.

Information provided by the Licensee did not identify dates when they communicated with the health care provider to discuss the resident's return to the Home. They stated that all parties were working together and had frequent conversations to arrange suitable living arrangements during the summer of 2020, but when the resident declined that option, communication was sporadic, and they were unable to provide details or dates.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 146. When licensee shall discharge

Specifically failed to comply with the following:

s. 146. (4) A licensee shall discharge a long-stay resident if,
(a) the resident is on a medical absence that exceeds 30 days; O. Reg. 79/10, s. 146 (4).
(b) the resident is on a psychiatric absence that exceeds 60 days; O. Reg. 79/10, s. 146 (4).
(c) the total length of the resident's vacation absences during the calendar year exceeds 21 days; or O. Reg. 79/10, s. 146 (4).
(d) the long-term care home is being closed. O. Reg. 79/10, s. 146 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #002 was discharged from the Home once their medical absence exceeded 30 days.

Resident #002 was transferred to the hospital for treatment on an identified date in 2020, and subsequently transferred to another health care provider as the Home was unable to accept the resident's return due to a COVID-19 outbreak.

Interview with the Home's Administrator (staff #103) identified that the home was unable to discharge the resident due to an outbreak of disease in the home, consistent with the Regulation. Upon resolution of the outbreak, the Licensee consulted with their legal support who advised that due to the pandemic situation occurring in the City of Toronto, that discharge would not be advised.

Staff #103 also identified that they had consulted with the placement coordinator regarding the possibility of discharging resident #002, and they were told that the placement coordinator was not certain this could be done given the pandemic situation in the City of Toronto.

At the time of the inspection, Resident #002 remained at another health care facility, and had not been discharged from the Home.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, before resident #001 was discharged, the Licensee worked in collaboration with the appropriate placement coordinator to make alternative arrangements for the accommodation, care and secure environment required by the resident.

Resident #001 was admitted to Sherbourne Place on an identified date in 2020.

This Home was not resident #001's first choice on their placement application, and as such resident #001 remained on the wait list for their first choice home. Both Sherbourne Place and the resident's first choice Home are operated by the same Licensee, the Rekai Centres.

Discussion with staff #102, who was responsible for overseeing both Homes for admission and discharge issues, identified that resident #001 was on the wait list for their first choice Home.

On an identified date in 2020, the Licensee discharged resident #001 from Sherbourne Place and moved them to an available bed at the resident's first choice Home.

Interview with staff #101, confirmed that this move was treated as a transfer between two Home's operating under the same Licensee. Administrator #101 confirmed that the move was done without input from the Local Health Integration Network (LHIN) placement coordinator.

Issued on this 24th day of June, 2021

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

Original report signed by the inspector.