Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report (A1)

Report Issue Date: March 02, 2023	
Inspection Number: 2023-1247-0002	
Inspection Type: Critical Incident System	
Licensee: The Rekai Centres	
Long Term Care Home and City: Sherbourne Place, Toronto	
Inspector who Amended April Chan (704759)	**Inspector who Amended Digital Signature** April W Chan Digitally signed by April W Chan Date: 2023.03.02 15:43:37 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to remove a finding from Non-Compliance #005. The Critical Incident System inspection #2023-1247-0002 was completed January 27, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 20, 23-27, 2023

The following intake(s) were inspected:
- Intake: #00003568 related to falls prevention
- Intake: #00005055 related to medication administration

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to ensure that written policies and protocols developed for the medication management system are complied with. Specifically, procedures to document interventions for a specific health condition was not performed for resident #001.

The home's policy had indicated procedures to be followed for the specific health condition. Staff members were instructed to document their interventions onto a specific form.

Rationale and Summary
The resident had experienced two episodes of a specific health condition. The Director of Nursing Services (DNS) indicated that staff members had followed procedures to intervene when the resident had the episodes but staff members had not documented their interventions. They acknowledged that the specific form should have been used as a tool to document but that was not done.

A registered nurse (RN) indicated that interventions for the resident should be documented in the progress notes. There was no documentation on the above-mentioned incidents.

There was risk identified for the resident when procedures to document interventions for a specific health condition was not performed. The home would not be able to identify trends in the health condition for the resident.

Sources: a critical incident report, review of the resident's clinical records, the home's policy on the specific health condition, interviews with an RN and DNS.

[704759]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of a specific medical monitoring for resident #001 as set out in the plan of care was documented.

Rationale and Summary
The resident required specific medical monitoring four times a day at specified times. The resident received medical monitoring on a specific date, at two specific times. The DNS identified that the resident's medical monitoring at the two specific times should be documented, but that was not done.

An RN indicated that the medical monitoring was documented in the specific records and in progress notes. There was no documented monitoring located for the resident for the above-mentioned care.

There was risk identified when the resident's specific medical monitoring as set out in the plan of care was not documented. The home would not be able to identify trends in fluctuations of a medical condition which may affect management of the resident's health.

Sources: review of the resident's assessments and clinical records, interviews with an RN and DNS.

[704759]

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs are administered to resident #001 in accordance with the directions for use as specified by the prescriber.

Rationale and Summary
The resident was prescribed two medications. On a specific date, the resident did not receive the first medication as ordered and received the second medication late. An RN indicated that they held the scheduled medications according to clinical judgement but did not notify the home's physician prior.

The DNS indicated that scheduled medications had an administration period. They identified that the physician should have been informed about the resident's condition so that they may provide new directions for drug administration.

There was risk identified when drugs were not administered to the resident in accordance with the directions for use as specified by the prescriber.

Sources: the resident's medication administration record (MAR), medication incident report, interviews with an RN and DNS.

[704759]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that resident #002 was reassessed, and the plan of care revised when the care set out in the plan has not been effective.

Rationale and Summary
The resident was at moderate risk for falls and had a history of falls. A falls prevention care plan was developed and implemented for the resident.

The resident had a fall without injury. A post fall huddle by registered staff and direct care staff was conducted. The plan was to implement further interventions. The post fall huddle note indicated that the care plan for the resident would be updated. There was no revision to the resident's falls prevention plan of care.

Registered staff and the DNS indicated that the resident's falls prevention plan of care after the fall should have been revised with new strategies or changes to interventions but that was not performed. Additionally, the DNS identified that the revision to the falls prevention plan of care could have been endorsed to the registered staff on the next shift.

There was risk identified when the resident's falls prevention plan of care was not revised when the care set out in the plan was not effective.

Sources: Critical Incident report, fall incident report, the resident's plan of care, clinical notes, interviews with staff, and DNS.

[704759]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control (IPAC).

The licensee failed to ensure that Routine Practices in the IPAC program were followed by three staff members in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, Routine Practices shall include hand hygiene, and are followed in the program as is required by Additional Requirement 9.1 under the IPAC Standard.

The home's IPAC policy entitled Hand Hygiene – Use of Alcohol-based hand rub (ABHR) states that use of hand sanitizers reduces germs and that the best way to use hand sanitizer is to apply a small amount and rub hands together for at least 15 seconds until dry. It also states that the four moments of hand hygiene includes after potential exposure to bodily fluids.

Rationale and Summary
A) On January 23, 2023, a screener did not follow hand hygiene procedures while assisting with COVID-19 rapid testing of staff and visitors of the home. The screener was observed using hand sanitizer and rubbing hands together for approximately 4 seconds. They identified that they should be rubbing their hands together for at least 15 seconds but was not aware they were rubbing for 4 seconds because they were busy.

On the same day, a housekeeper did not follow hand hygiene procedures after sweeping a corridor. They were observed rubbing their hands together with hand sanitizer for approximately 4 seconds. The housekeeper identified for hand hygiene that they should be rubbing hands together with sanitizer for 3 seconds.

The DNS and IPAC lead indicated that staff members were expected to rub hands together for 15 seconds. The IPAC lead identified that there was a risk of ineffective hand hygiene when hand rubbing was not done for 15 seconds or until dry.

There was risk identified when staff members did not follow proper hand hygiene procedures.

B) On January 23, 2023, a staff member did not perform hand hygiene after conducting a nasal

collection from themselves at the asymptomatic COVID-19 screening station.

The screener indicated that the staff member was a registered nursing staff and was permitted to self-collect nasal specimens for COVID-19 screen testing. The IPAC lead and DNS indicated that hand hygiene was to be performed before and after the staff member conducts a nasal specimen collection on themselves.

There was risk of infectious disease transmission at the test waiting area when a staff member did not follow hand hygiene procedures during a nasal collection from themselves.

Sources: the home's policy entitled Hand hygiene – use of ABHR (Alcohol-based hand rub), observations on January 23, 2023, interviews with staff members, IPAC lead and DNS.

[704759]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that resident #001's written plan of care set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
The resident was prescribed a drug with dosage based on a variable scale according to a medical sign. A review of the resident's medication administration record did not identify when to measure the medical sign to calculate the variable scale for the prescribed medication.

Two registered staff indicated that their practice of when to measure the medical sign was prior to meals. During a day shift, the resident was administered the drug according to the medical sign after a meal. The registered staff member stated that monitoring and drug administration was done after meal because it was busy during mealtime.

Another registered staff also indicated that their practice of when to measure the medical sign for the resident was prior to meal and after meals. They usually administered the drug when the resident started to eat. On occasion, they would measure the resident's medical sign again after meal and then

administer the drug based on the variable scale according to measurements taken after meal.

Registered staff and DNS stated that it was not specified in the resident's MAR whether measuring the medical sign and drug administration should be done before or after meals.

A registered nurse identified risk to the resident when medical sign measurements and drug administration is done after meals because the resident may receive more drug dosage based on variable scale which may lead to an adverse medical condition.

Sources: the resident's MAR, interviews with staff members, and DNS.

[704759]