Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: December 21, 2023
Original Report Issue Date: December 12, 2023
Inspection Number: 2023-1247-0004 (A1)
Inspection Type:
Complaint
Critical Incident

Licensee: The Rekai Centres
Long Term Care Home and City: Sherbourne Place, Toronto

Amended By	**Inspector who Amended Digital Signature**
Carole Ma (741725)	Carole Ma (741725)

AMENDED INSPECTION SUMMARY

This report has been amended to:
-Revise details in the Compliance Order (CO) steps regarding the hopper
-Extend the compliance due date for CO #001

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Amended Public Report (A1)

Amended Report Issue Date: December 21, 2023	
Original Report Issue Date: December 12, 2023	
Inspection Number: 2023-1247-0004 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: The Rekai Centres	
Long Term Care Home and City: Sherbourne Place, Toronto	
Lead Inspector Carole Ma (741725)	**Additional Inspector(s)**
Amended By Carole Ma (741725)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
-Revise details in the Compliance Order (CO) steps regarding the hopper
-Extend the compliance due date for CO #001

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20 - 23, 27, 2023

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The following Critical Incident intake was inspected:
· Intake: #00100182 - Related to a disease outbreak

The following Complaint intake was inspected:
· Intake: #00100765 - Related to infection prevention and control (IPAC), staffing shortages

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

Resident Care and Support Services
Infection Prevention and Control

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)
24-hour nursing care
s. 11 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee failed to ensure that at least one Registered Nurse (RN) was on duty

and present in the home for multiple shifts during a specified period of time.

Rationale and Summary
Nursing schedules for weekends during a specified period of time were reviewed.

The Director of Nursing Services (DNS) confirmed that an RN was not on-site for day shifts on multiple occasions. They indicated the home had attempted but was unable to find an RN from within the home's roster and agencies. They maintained they and the Director of Resident Care (DRC) were both RNs and were available by telephone during these times.

Failure to have an RN on-site on multiple occasions left a leadership void on weekends and placed residents at risk should an emergency situation arise.

Sources: Weekend nursing schedules, Interview with DNS. [741725]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee failed to ensure the policies in the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes (LTCHs) were carried out.

Rationale and Summary
1) The home failed to comply with the directive regarding outbreak management.

The directive referred to requirements set out in the COVID-19 Guidance Document for LTCHs in Ontario, last revised November 7, 2023. This guidance document stated that homes must follow the guidance and direction from their local public health unit in the event of a suspected or confirmed outbreak to reduce the risk of COVID-19 transmission in the setting.

A Critical Incident System (CIS) report was submitted on the same day that Toronto Public Health (TPH) declared the home was in a COVID-19 outbreak.

A completed COVID-19 outbreak management checklist was signed by TPH when a specific floor was in a COVID-19 outbreak. The home was required to conduct active screening for staff and visitors working in the outbreak area, prior to entering the building.

A Registered Practical Nurse (RPN) who worked on an outbreak floor indicated that they had not conducted any active screening before entering the building. The Nursing Administrative Manager (NAM) and IPAC lead both acknowledged the home did not implement active screening of staff and visitors prior to them entering the building and proceeding to an outbreak floor.

Failure to comply with this measure provided by TPH to reduce the risk of COVID-19 transmission placed residents at increased risk for exposure and a prolonged outbreak.

Sources: CIS report, COVID-19 outbreak management checklist, Interviews with RPN, NAM, IPAC lead. [741725]

2) The home failed to comply with the directive regarding a COVID-19 outbreak preparedness plan. The directive referred to requirements set out in the COVID-19

Guidance Document for LTCHs in Ontario, last revised November 7, 2023. This guidance document stated that when in a COVID-19 outbreak, homes must complete weekly IPAC audits.

A CIS report was submitted on the same day that TPH declared the home was in a COVID-19 outbreak. The outbreak was finalized five weeks later.

The home completed an IPAC audit on a specific date and the next one was completed 10 days later.

The IPAC lead confirmed the home did not complete weekly IPAC audits during the outbreak.

Failure to complete weekly IPAC audits during a COVID-19 outbreak placed residents at risk for exposure and a prolonged outbreak.

Sources: CIS report, IPAC audits, Interview with IPAC lead. [741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The home failed to ensure that on every shift symptoms of an infection for two

residents were recorded as required.

Rationale and Summary
Two residents contracted an infection and remained on isolation for a period of time. During this time, the home failed to record their symptoms every shift, on multiple dates.

The IPAC lead confirmed missing documentation of monitoring symptoms for these two residents while they were on isolation.

Failing to monitor COVID-19 positive residents placed residents at risk for a potential delayed response to a worsening condition.

Sources: Residents's clinical records, Email from IPAC lead. [741725]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall
1.Ensure where hoppers are still in use, to provide training to staff on appropriate

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personal protective equipment (PPE) use and ensure a cleaning process of hoppers and the surrounding area is in place
a)Keep a documented record of contents of education provided, names of who provided and received education, date education was provided
b)Keep a documented record of the cleaning policy that includes hoppers

2.Disconnect the hopper spray wand on every floor
a) Keep a documented record of work orders and invoices, name of person or company completing the work, and date(s) when work has been completed

3.Educate nursing staff on the discontinuation of using hopper for the rinsing of soiled clothing and linens
a) Keep a documented record of contents of education provided, names of who received and who provided the education, date education was provided

4.Educate a specific Personal Support Worker (PSW) and Essential Visitor (EV) on appropriate use of PPE during respiratory outbreak, that includes when providing direct care and in common areas
a) Test the PSW on the education content and if the score is below 80 percent, repeat education and test
b) Keep a documented record of contents of education provided, names of who received and who provided the education, date education was provided, completed test for the PSW showing marked score

5.Educate all PSWs on second floor on the four moments of hand hygiene (HH)
a) Conduct HH audits during lunch and dinner service for one week on second floor and provide on-the-spot education where required
b) Keep a documented record of contents of education provided, names of who received and provided the education, date education was provided.

c) Keep a documented record of all HH audits that includes the date and time of the audit, the name of the person conducting the audit, all on-the-spot education provided that includes name of persons providing and receiving education, content of education provided and date education provided

Grounds
The licensee shall implement any standard or protocol issued by the Director with respect to IPAC.

Rationale and Summary
1) The licensee failed to ensure the IPAC Standard for Long Term Care Homes April 2022, revised September 2023, was complied with. Specifically, additional requirement section 5.8 directed the home to make every effort to eliminate the use of hoppers, which included eliminating the rinsing of soiled items. Where hoppers were still in use, the spray wand was to be disconnected to ensure it was not used and IPAC measures needed to be in place to minimize the risk of infection to staff as well as soiling of the surrounding area.

The home had hoppers in use on each of its three floors. A PSW confirmed that dialysis effluent bags were emptied into hoppers and that heavily soiled clothing and linens were rinsed in hoppers before being sent to laundry. They demonstrated the spray wand was still attached and functional, and indicated that it was also used to help remove soiled material. During this process, the PSW indicated they wore only gloves and that there was no splashing onto their clothing or surrounding area.

An RN confirmed hoppers were used to rinse heavily soiled items before being sent to laundry.

The home's policy on routine practices indicated that gowns and plastic aprons should be worn to protect uncovered skin and to prevent soiling of clothing during procedures that may involve splashes or sprays of blood, other body fluids, secretions, or excretions. The policy also pointed out that soiled uniforms can act as a "source" or "reservoir" and promote organism transmission.

The IPAC lead could not confirm if hoppers were used in the home. They were unaware of how hoppers and the surrounding area were cleaned, and what type of personal protective equipment (PPE) requirements were in place when using them.

Failing to eliminate the use of the hopper’s spray wand, not enforcing PPE requirements for staff when a hopper was being used, and an unclear process for sanitizing hoppers and the surrounding area placed residents at risk for infection exposure and transmission.

Sources: Observations, policy on routine practices, Interviews with a PSW, RN and IPAC lead. [741725]

2) The licensee failed to ensure the IPAC Standard for Long Term Care Homes April 2022, revised September 2023, was complied with. Specifically, Additional precaution 9.1 (f) directed the home to include additional personal protective equipment (PPE) requirements that involved appropriate selection and application.

A CIS report was submitted on the same day that TPH declared the home was in a COVID-19 outbreak.

A completed COVID-19 outbreak management checklist was signed by TPH. The home was to ensure that face shields be worn at all times on outbreak units and recommended that EVs must follow all IPAC measures during their visit.

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A number of observations were made on a floor that was on a confirmed COVID-19 outbreak. On the first day, a specific PSW was observed at the nursing station wearing an N95 mask and no face shield or goggles. They indicated that they only needed to wear a face shield when providing direct care, despite there being residents on the unit who frequently wandered out of their rooms. During this observation, a resident was walking around and standing at the nursing station. The PSW, wearing only an N95 mask, then carried a lunch tray down the hall and passed by a second resident.

During the same observation period, an EV was also standing by the nursing station and wearing only a surgical mask. They indicated that the N95 masks did not fit them and that they wore a face shield when providing direct care. On two other days, the EV was observed wearing an N95 mask and no face shield or goggles while standing by the nursing station. They indicated they were not told to put on a face shield or goggles while on the second floor.

On one occasion, the DNS was observed walking the length of the hallway from the stairs to the elevators, wearing only an N95 mask and no face shield or goggles. Later that day, the DNS acknowledged they should have also worn a face shield or goggles while on the second floor.

The IPAC lead confirmed that the home's policy and expectations were for staff and EVs to wear an N95 mask and face shield or goggles for the entire time they are on an outbreak unit.

Failure to comply with this measure placed residents at increased risk for infection and a prolonged outbreak.

Sources: CIS report, Observations on outbreak floor, COVID-19 outbreak management checklist, Interviews with a specific PSW, specific EV, DNS and IPAC lead. [741725]

3) The licensee failed to ensure the IPAC Standard for Long Term Care Homes April 2022, revised September 2023, was complied with. Specifically, Routine practice 9.1 (b) directed the home on HH practices that were required to be conducted at the four moments, which included before and after resident/resident environment contact.

A CIS report was submitted on the same day that TPH declared the home was in a COVID-19 outbreak.

On a specific date and outbreak floor, multiple PSWs were observed carrying lunch trays into resident rooms without performing HH upon entry and/or exit. For example, a PSW was observed entering a resident's room to provide meal assistance without performing HH. The same PSW then exited and re-entered the same room to continue providing meal assistance, again without performing HH.

The IPAC lead confirmed HH should be performed as required by the four moments of hand hygiene.

Failing to conduct HH according to the four moments placed the resident at risk for COVID-19 infection and a prolonged outbreak.

Sources: CIS report, Observations, Interview with IPAC lead. [741725]

This order must be complied with by April 1, 2024

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.