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

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Original Public Report

Report Issue Date: September 17, 2024

Inspection Number: 2024-1247-0002

Inspection Type:
Critical Incident

Licensee: The Rekai Centres

Long Term Care Home and City: Sherbourne Place, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 15, and 16, 2024. The inspection occurred offsite on the following date(s): August 27, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00113746 - CI#2754-000008-24 - Respiratory outbreak
- Intake: #00113951- CI #2754-000009-24 - Enteric outbreak
- Intake: #00116153 - CI #2754-000011-24 - COVID-19 outbreak
- Intake: #00121266 - CI #2754-000016-24 - Missing resident

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

Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care included the planned care for a resident.

Rationale and Summary
A resident required a specific intervention for their safety and responsive behaviours.

An observation revealed this specific intervention was in place, however there was no mention of it in the resident's care plan.

The Director of Resident Care (DRC) acknowledged that the care plan did not include this specific intervention.

Failing to ensure the written plan of care included the planned care for the resident increased the risk of staff and others not being aware of their planned care.

Sources: Observation; resident's care plan; interviews with the PSW, the DRC and others.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's care intervention was implemented as specified in their plan of care.

Rationale and Summary
A resident had a history of a specific responsive behaviour. The resident's care plan directed staff to perform a specific intervention, however an observation revealed the intervention was not in place.

The resident confirmed that the intervention had not been implemented.

A PSW and the DRC acknowledged that the specific intervention was not provided to the resident.

Failing to ensure the intervention specified in the resident's care plan was in place put them at risk for harm.

Sources: Observation; resident's care plan; interviews with the resident, PSW and DRC.

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains,

contact surfaces and wall surfaces, and

The licensee has failed to ensure that procedures were implemented for cleaning of the home, including resident bedrooms, furnishings, contact surfaces, and wall surfaces.

Rationale and Summary
A Housekeeper (HSK) was observed cleaning multiple residents rooms using the same cleaning cloths, specifically cleaning the contact surfaces, furnishings, and the bathroom. The HSK went room to room using one green cleaning cloth for the all the bedrooms and one red cloth for all the bathrooms in these rooms.

The home's Daily Resident Room Cleaning policy stated that one cleaning cloth was to be used for each resident's room to prevent transfer of germs.

The Environmental Services Manager (ESM) acknowledged that the HSK should have changed their cleaning cloth between residents rooms and bathrooms.

There was increased risk of spreading microorganisms between residents when the HSK failed to follow the home's cleaning procedures.

Sources: Observations, Daily Resident Room; interviews with the HSK and ESM.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
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 licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 10.2 (c) states that licensee shall ensure that the hand hygiene program for residents has a resident centered approach with options for residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks. Specifically, the licensee has failed to provide hand hygiene to all residents prior to and after eating.

Rationale and Summary
An observation revealed that specific residents did not receive assistance with hand hygiene during the lunch meal service. PSWs who assisted with the lunch meal service were observed serving meal trays without providing hand hygiene assistance to these residents.

The residents confirmed they were not offered assistance with hand hygiene before their lunch meal. A PSW acknowledged they should have assisted the residents with their hand hygiene before the meal service.

Infection Prevention and Control (IPAC) Lead acknowledged that staff were expected to provide hand hygiene assistance to all residents before meals.

Failing to provide hand hygiene assistance to residents put them at risk for infection.

Sources: Observations; interviews with the residents, PSWs, and IPAC Lead.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee has failed to report and submit a critical incident as provided for in the legislation.

Rationale and Summary

A resident's clinical records showed they were involved in a specific incident, however there was no corresponding critical Incident Report (CIR) submitted to the Director for this incident.

The Director of Nursing (DON) acknowledged that a CIR was not submitted for the incident.

Failure to report the incident as provided for in the legislation prevented the Director from taking actions where applicable.

Sources: CIR, resident's clinical records; interview with the DON.