

**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

## Public Report

**Report Issue Date:** May 30, 2025

**Inspection Number:** 2025-1247-0003

**Inspection Type:**

Proactive Compliance Inspection

**Licensee:** The Rekai Centres

**Long Term Care Home and City:** Sherbourne Place, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 16, 20, 22-23, 26-30, 2025

The inspection occurred offsite on the following date(s): May 27, 2025

The following intake(s) were inspected:

- Intake: #00146510 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services  
Skin and Wound Prevention and Management  
Medication Management  
Food, Nutrition and Hydration  
Residents' and Family Councils  
Safe and Secure Home  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Staffing, Training and Care Standards  
Quality Improvement  
Residents' Rights and Choices

**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

Pain Management

## INSPECTION RESULTS

### Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.**

Posting of information

s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:

10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

The visitor policy was not initially posted; however, it was displayed promptly after the matter was brought to the Executive Director's attention.

**Sources:** Observations; and interview with the Executive Director.  
[741674]

Date Remedy Implemented: May 16, 2025

**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

## WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.**

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

- 19. Every resident has the right to,
  - iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure that residents had their personal health information kept confidential in accordance with that Act.

Two registered staff members had left their medication cart computer screen with residents Personal Health Information exposed. There were several residents and staff in and around the areas at the time of the observations.

**Sources:** Observations of medication carts on two different residents home areas, interview with two Registered Practical Nurses (RPNs).

[698]

## WRITTEN NOTIFICATION: Plan of Care

NC #003 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

**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

to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A cup of coffee and a labeled beverage were served to a resident in regular consistency, while the two other beverages were served in thickened consistency. It was noted that none of the beverages were provided in the consistency as specified in the resident's plan of care. Two Food Service Managers (FSMs) were informed of the matter, and they confirmed that the resident was at risk of aspiration and choking when fluids were not provided in the consistency indicated in their plan of care.

**Sources:** Observation of dining service, review of the resident's clinical records, interviews with two FSMs.

[741672]

**WRITTEN NOTIFICATION: Reporting certain matters to  
Director**

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an allegation of abuse was immediately reported

**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

to the Director.

A resident reported an allegation of abuse to a charge nurse who reported this information to the Director of Care (DOC) on the same day, but it was not reported to the Ministry of Long Term Care Director.

**Sources:** Resident's clinical records; and interview with the DOC.

[741674]

## **WRITTEN NOTIFICATION: Dining and snack service**

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

**Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.**

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee failed to ensure that the assistive devices and personal assistance provided to a resident supported safe eating and drinking, as well as comfort and independence, as required.

A resident was fed using an assistive feeding device that was not indicated in their plan of care. Two Food Services Managers (FSMs) confirmed that residents on modified texture diets should not be fed using this device unless it has been assessed and approved by the Registered Dietitian (RD).

**Sources:** An observation of dining service, interviews with two FSMs, review of the

**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

resident's clinical records and policy titled "Resident Special Needs".

[741672]

**WRITTEN NOTIFICATION: Dining and snack service**

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)**

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required by the resident.

A resident who required assistance with eating was served food without any staff available to provide the necessary assistance. A Personal Support Worker (PSW) acknowledged that they were not supposed to serve food to the resident when they were not available to assist them with eating.

**Sources:** An observation of dining service, review of policy titled "Meal Service In Dining Room", and resident's clinical records, interview with a PSW, and two FSMs.

[741672]

**COMPLIANCE ORDER CO #001 Infection prevention and control program**

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**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

**Non-compliance with: O. Reg. 246/22, s. 102 (8)**

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

**The inspector is ordering the licensee to comply with a Compliance Order  
[FLTCA, 2021, s. 155 (1) (a)]:**

Specifically, the licensee shall:

1. Provide education to a PSW on the proper application of Personal Protective Equipment (PPE) for additional precautions and the home's policy and procedures related to the application of PPE.
2. Maintain a written record of the education provided to the PSW, and include the date of the education, the name of the person(s) providing the education.
3. Conduct three randomized audits on the PSW of the proper application of PPE for residents additional precautions.
4. Maintain a written record of the audits conducted on the PSW, including the date of the audit, name of the person(s) conducting the audit, and discrepancies and corrective actions taken, if any.

**Grounds**

**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

The licensee failed to ensure that a PSW participated in the implementation of the home's infection prevention and control program related to proper use of Personal Protection Equipment (PPE).

A PSW entered a shared room on droplet and contact precautions (DCP) wearing only a surgical mask to assist the residents with hand hygiene. The signage outside of the shared room indicated they were required to wear full PPE including a gown, mask, gloves and a face shield. They failed to follow the posted signage that required them to wear a gown, mask, gloves and face shield.

Failure to adhere to the posted signage put residents at risk for infection.

**Sources:**

An observations; 24 Hour Report; and interview with a PSW.



**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

[741674]

**This order must be complied with by**

July 10, 2025

**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

## 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, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

**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

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, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**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

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto: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](http://www.hsarb.on.ca).