Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 5, 6, 7, 11, 2012	2012_083178_0021	Critical Incident

Licensee/Titulaire de permis

DRS PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3

Long-Term Care Home/Foyer de soins de longue durée

DRS. PAUL AND JOHN REKAI CENTRE
345 SHERBOURNE STREET, TORONTO, ON, M5A-2S3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Residents Care (DRC), Registered Staff, Health Care Aides (HCAs), Receptionist, a resident.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home policies, observed staff-to-resident interactions.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Resident records and staff interviews reveal that the licensee's policy Abuse and Neglect of a Resident-Actual or Suspected (VII-G-10.00) was not complied with after an alleged abuse incident on Nov 5, 2011.
The policy Abuse and Neglect of a Resident-Actual or Suspected states that if a staff member or volunteer becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, co-worker, the Charge Nurse will
-immediately notify DOC/Administrator
-initiate the Nursing Checklist for Reporting and Investigating Alleged Abuse.
The RN in Charge will continue completion of Nursing Checklist for Reporting and Investigating Alleged Abuse.
This procedure was not followed by Registered staff on Nov. 5, 2011.
At approximately 04:30h on Nov 5, 2011 an identified resident reported to the RN and RPN in charge that he/she had been scratched by an identified Health Care Aide (HCA) while she delivered his/her care that night. The resident showed the registered staff three scratches, stating that they had been caused by the Health Care Aide, and cited this as his/her reason for slapping the Health Care Aide in the face.

The Registered Practical Nurse(RPN) in charge of the resident did not initiate the Nursing Checklist for Reporting and Investigating Alleged Abuse. The RPN informed the Director of Residents' Care (DRC) at the end of the shift that the resident had slapped the HCA, but did not report to her the resident's allegations of abuse.
The Registered Nurse (RN) in Charge did not continue completion of the Nursing Checklist for Reporting and Investigating Alleged Abuse, as directed in the licensee's policy.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy Abuse and Neglect of a Resident-Actual or Suspected (VII-G-10.00) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Registered staff on duty on the night of November 5, 2011 did not immediately report to the Director under the LTCHA, a resident's allegation that he/she was abused by a staff member.

Resident records and staff interviews reveal the following:
At approximately 04:30h on Nov 5, 2011 an identified resident reported to the RN and RPN in charge that he/she had been scratched by an identified Health Care Aide (HCA) while she delivered his/her care that night. The resident showed the registered staff three scratches, stating that they had been caused by the Health Care Aide, and cited this as his/her reason for slapping the Health Care Aide in the face.
Registered staff did not report the allegations to the MOHLTC.
Registered staff informed the Director of Residents Care (DRC) at the end of their shift that the resident had slapped the HCA, but did not report to the DRC the resident's allegations of abuse.

The abuse allegations were again reported by the resident in a letter to the DRC on November 6, 2011, at which time the DRC reported the allegations to the Director under the LTCHA.

Issued on this 11th day of June, 2012

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

Shawn Lin (178)