Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 4, 2015	2015_398605_0008	T-581-14, T-743-14, T-874-14, T-918-14	Critical Incident System

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

WELLESLEY CENTRAL PLACE
160 WELLESLEY STREET EAST TORONTO ON M4Y 1J2

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

SARAH KENNEDY (605)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 13, 14, 15, 16 & 17, and June 29, 2015.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Services (DNS), Personal Support Workers (PSWs), Registered Nursing Staff, residents and substitute decision makers.

During the course of the inspection, the inspector(s) observed staff to resident interaction, reviewed resident and home records, reviewed relevant home policies and reviewed Toronto Police investigation notes.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

A Critical Incident (CI) report was submitted in April, 2014, indicating an identified PSW student reported to staff member #100 that she witnessed PSW #101 be abusive towards resident #001, #002 and #003. Police were notified and an investigation was initiated. PSW #101 was removed from the home.

Wellesley Central Place was unable to provide any internal investigation notes. Staff member #100 was contacted and could not recall any details about the alleged abuse.

Police investigation notes were obtained and reviewed. Review of the police investigation notes revealed the PSW student reported witnessing PSW #101 physically abuse four identified residents: resident #001, #002, #003 and #007. Review of the PSW students witness statement revealed the following:

1. While PSW #101 was providing care for resident #001 the PSW student observed PSW #101 hit resident #001's head against the wall 2-3 times. The student also observed PSW #101 throw mouthwash at resident #001's face during oral care. The resident then vomited. Another identified PSW student reported that she observed PSW #101 physically force resident #001 to take mouthwash.

2. The PSW student observed PSW #101 transfer resident #003. The resident's legs were not properly placed in the lift and PSW #101 left the residents legs dangling and dragged her to the bathroom.

3. Resident #007 was lying in bed and the PSW student observed PSW #101 move the resident's leg. The resident reportedly screamed out in pain.

4. The PSW student was helping PSW #101 transfer resident #002 to the bathroom for his/her shower. The resident soiled his/her incontinence product and the student observed PSW #101 yell and verbally abuse the resident.

Inspector #605 was unable to interview residents #001 and #003. Residents #002 and #007 are deceased.

Contact with Toronto Police Services revealed that PSW #101 has been criminally charged. The case is currently before the courts.

An interview with the PSW student confirmed that what she witnessed at Wellesley Central Place was abuse.

Based on the PSW student's observations and the police investigation with subsequent criminal charges being laid against the accused employee, the home has failed to ensure the residents were protected from abuse. [s. 19. (1)]

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 residents are protected from abuse by anyone, 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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by the licensee or staff, resulting in harm or risk of harm, immediately report the suspicion to the Director.

An identified registered staff member submitted a Critical Incident (CI) report in May, 2014. The incident of alleged staff to resident abuse took place earlier in May, 2014. Resident #004 reported to management that an identified registered staff member yelled at him/her saying that he/she wouldn't look at resident #004's wound. The registered staff member was sent home on paid leave. A few days after the incident was reported, resident #004 revealed to management that he/she overreacted and didn't think the staff member was being abusive.

An interview with the Director of Nursing Services confirmed that the CI report was not submitted immediately and that the expectation is that suspected abuse or neglect should be reported to the Director immediately. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by the licensee or staff, resulting in harm or risk of harm, immediately report the suspicion to the Director.

An identified staff member submitted a Critical Incident (CI) report in April, 2014. The CI report revealed that an identified PSW student reported to staff member #100 that she witnessed staff #101 being physically abusive with residents #001, #002 and #003. The CI report stated that an investigation had been initiated and the police were contacted. The alleged staff member was suspended and removed from the building.

An interview with an identified staff member, who requested to remain anonymous, revealed that the PSW student reported the alleged abuse to staff #100, a few days before the CI report was submitted.

Review of the police investigation notes revealed that the Administrator received an email about the alleged abuse from staff #100 on an identified date.

An interview with the Director of Nursing confirmed that the home did not immediately report to the Director the suspected incident of abuse/neglect. [s. 24. (1)]

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Issued on this 4th day of December, 2015

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

Original report signed by the inspector.