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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 27, 2017 | 2016_356618_0023 | 031306-16, 031487-16 | Complaint |

## 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

CECILIA FULTON (618)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): October 28, 31, November 1, 2, 3, 2016.**

**This inspection was conducted current with the Resident Quality Inspection (RQI).**

**During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Resident Services (DORS), Resident and Family Services Relation Co-ordinator, Residents and Resident's Substitute Decision Makers (SDM).**

**During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care and reviewed clinical health records.**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other.

Review of a Critical Incident Report, dated October 2016, revealed that on an identified date in October 2016, a family member of resident #006 reported a concern to the Family and Resident Relation Coordinator, staff #100.

A written statement made by staff #100 on an identified date in October 2016 to the Executive Director (ED) revealed that resident #006 carries a potentially dangerous item with them.

Inspector interview with staff #100 confirmed that resident #006 had disclosed this information about keeping a potentially dangerous item on an identified date in October 2016.

An interview with registered nurse staff #111 revealed on an identified date in November 2016 they had not been made aware that this resident carries this item with them, and when made aware, staff #121 removed the item from the resident. Interview with the Director of Resident Care Services (DORS) staff #103 revealed that they had not been informed that resident #006 carries this item with them and on being made aware of this ordered the item to be removed and the care plan to be updated to include staff monitoring of the resident.

Interview with the DONS #102 confirmed that the information regarding the resident carrying this item had not been communicated to staff and that the care plan had not been updated until an identified date in November 2016. [s. 6. (4) (a)]

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**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 that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Review of Critical Incident Report dated October 2016 revealed that on an identified date in October 2016 at 1630 hours the Resident and Family Services Relation Co-ordinator, staff #100 had received a complaint of alleged abuse from a resident's family member. According to the CIR the family member reported an alleged staff to resident abuse involving resident #007.

On an identified date in October 2016, the same family member who reported this allegation to the home also reported this to the MOHLTC's info line. On receipt of the information received through MOHLTC info line, Inspectors #109 and #618 visited the home and met with the home's Executive Director (ED) and Director of Resident Services (DORS). Neither of these staff members had been informed of the allegation or had any knowledge about the alleged abuse.

The police were called by the home and an investigation was initiated.

Interview with staff #100 revealed that on an identified date in October 2016, they were informed by a family member of resident #006 about an alleged abuse involving resident #007. According to staff #100, they were aware of zero tolerance of abuse, and the mandatory/ immediate reporting policy, but because they were distracted by other duties they did not report the alleged abuse as they are required to do.

Review of the home's policy "Abuse or Neglect Policy", Index I.D. P-10, dated December 19, 2000, indicates that on becoming aware of abuse or neglect the person first having knowledge of this shall immediately inform the Director at the Ministry of Health and Long Term Care (MOHLTC).

Interview with DORS #102 revealed that staff should be aware of the reporting requirements, and that any staff member is expected to make the report to the Director at the MOHLTC.

Interview with the home's ED confirmed that the alleged abuse was not immediately reported to the MOHLTC Director. [s. 24. (1)]

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**Issued on this 31st day of January, 2017**

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

**Original report signed by the inspector.**