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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2017	2017_642606_0014	023890-17	Resident Quality Inspection

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

JANET GROUX (606), BABITHA SHANMUGANANDAPALA (673), JOVAIRIA AWAN (648)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 19, 20, 23, 24, 25, 26, and 27, 2017.

During the Resident Quality Inspection (RQI), the following intakes were inspected in concurrent with the RQI:
Complaint regarding the Residents Bill of Rights, Duty to Protect, Responsive Behaviours, Skin and Wound Care, Continence Care and Bowel Management, and Breach of Confidentiality.
Follow Up (FU) inspection #2016_356618_0024 regarding Duty to Protect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing Services (DNS), Director of Resident Services (DRS), Resident Services Coordinator (RSC), Physiotherapist (PT), Dietitian, Maintenance Manager, Hair Stylist, Life Enrichment Coordinator(LEC), Dietary Aides (DA), Housekeeping, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Substitute Decision Makers SDM), Private Duty Caregiver (PDC), and Residents.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed a resident administration, observed infection control staff practices, interviewed the Residents' Council (RC) President, completed a survey with the Family Council (FC) President reviewed, resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_356618_0024	606

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of an identified home's policy indicated that medication reviews are received by the home between an identified date each month. Each medication review is checked and updated by checking all physicians' orders since the previous medication review was signed. The nurse updating the review signs and dates the appropriate space at the bottom of the review. All new orders must be added to the bottom of the medication review. After the registered staff completes this check; two horizontal lines are drawn at the bottom of the most recent physician's order with the following information "QMR, date and initials". The physician and the registered staff reviewing the quarterly medication review are responsible for ensuring that any new order post the date of the initial check is added to the QMR prior to the approval by the physician.

During the Resident Quality Inspection's (RQI) mandatory inspection of the home's medication management system, a review of resident #009's physician orders indicated the resident was ordered an identified medication.

Review of resident #009's Medication Administration Records (MARs) on an identified date indicated the resident was administered the above mentioned physician order as indicated. However, review of resident #009's QMR dated on identified dates did not include the physician's order of the above mentioned order.

Interviews with RPN #123 and RN #125 indicated that the home's practice was to ensure that all the physician orders for the past three months are included in the QMR, reviewed and signed by the physician. They indicated that it was the responsibility of the registered staff to check on days, and on nights to ensure that the QMR was accurate and that all physician orders to be administered to the resident was accounted for in the QMR.

Interview with the DRS indicated the home's policy was for two registered staff to check and sign the QMR after it had been reviewed by the physician to ensure that the QMR was accurate. The DRS indicated that the physician's order for resident #009 as mentioned above should have been on the QMR but was missed. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were locked when they are not being supervised by staff.

Observations of the home made during stage one and stage two of the RQI identified an identified room on an identified floor to be open and unattended at the following times:

- On an identified date and time, inspector #673 noted biohazardous waste container in the open room.
- On an identified date and time noted biohazardous waste containers on the counter top and used resident care items. No staff were noted in the vicinity.

Interview with PSW #105 indicated the identified room was not a residential area and was expected to be closed and locked at all times when not in use by staff. PSW #105 confirmed the room was open at the time of the inspector's observation and subsequent interview shortly thereafter. PSW #105 identified and confirmed the biohazardous waste containers on the counter top with resident personal care items posed a safety risk to wandering residents on the locked unit. PSW #105 confirmed the room was not locked when it was not supervised by staff.

Interview with the DNS identified residents were not afforded access to the identified rooms. These rooms were expected to remain closed and locked at all times and only staff are expected to have access to these rooms. The DNS identified items and supplies stored in the rooms posed a safety risk to residents in the home. The DNS acknowledged the observations and indicated the identified room the locked on the identified unit and indicated residents on the identified unit were at higher risk related to wandering on the unit. The DRS acknowledged the legislative requirement to ensure all doors leading to non-residential areas were closed and locked when not supervised by staff. [s. 9. (1) 2.]

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 doors leading to non-residential areas with locks equipped to restrict access to those areas by residents are locked when they are not supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, that the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During stage one of the RQI, resident #005 triggered for potential for restraints during an observation of resident #005 having a bed rail in the up position located at the top half of the bed on the right side and his/her bed up against the wall on the left side.

Review of resident #005's assessments in Point Click Care (PCC) did not indicate resident #005 was assessed to use a bed rail.

Review of resident #005's written plan of care indicated that the resident required assistance for mobility/bed mobility related to identified medical conditions. There was no evidence in the careplan that directed staff for resident #005 to have a bed rail when the resident was in bed.

Interview with PSW #110 indicated that he/she puts up the bed rail for resident #005 to use to support him/herself during care and transfers in and out of bed.

Interview with the Physiotherapist (PT) indicated that any resident who was using a bed rail that may be considered as a restraint are assessed by him/her prior to the resident

using the bed rail. He/she indicated he/she did not assess resident #005's to use a bed rail.

Interview with the DRS indicated it was the home's practice that any resident who uses a bed rail must be assessed by the PT prior to using the bed rail and are assessed quarterly afterwards.

Interview with the DNS indicated that resident #005 was not assessed to have a bed rail because the resident indicated that he/she did not require a bed rail and indicated resident #005 was able to move in and out of bed by him/herself and does not require the use of a bed rail. The DNS indicated he/she was unaware that staff were using a bed rail for resident #005 and should not have been. [s. 15. (1) (a)]

2. During stage one of the RQI, resident #002 triggered for potential for restraints during an observation of resident #002 having a bed rail in the up position located at the top half of the bed on the right side and the bed up against the wall on the left side.

Review of resident #002's assessments in Point Click Care (PCC) did not indicate resident #002 was assessed to use a bed rail.

Review of resident #002's written plan of care indicated that the resident required assistance for mobility/bed mobility related to identified medical conditions. There was no evidence in the care plan that directed staff for resident #002 to have a bed rail up when he/she was in bed.

Interview with resident #002 indicated that he/she liked to have the bed rail up when he/she is in bed for comfort and security and to prevent him/her from falling out of the bed.

Interview with PSW #100 indicated that resident #002 will usually request to have his/her the bed rail when he/she was in bed because the resident was afraid of falling. The PSW indicated that he/she would put the bed rail up every time the resident was in bed.

Interview with the Physiotherapist (PT) indicated that any resident who was using a bed rail that may be considered as a restraint are assessed by him/her prior to the resident using the bed rail. He/she indicated he/she did not assess resident #002 to use a bed rail.

Interview with the DRS indicated it was the home’s practice that any resident who uses a bed rail must be assessed by the PT prior to using the bed rail and reassessed quarterly afterwards.

Interview with the DNS indicated that resident #002 was not assessed to use a bed rail because the resident indicated to him/herself that he/she did not require one. He/she was unaware that staff were putting up a bed rail up for resident #002 when he/she is in bed. [s. 15. (1) (a)]

3. During stage one of the RQI, resident #001 triggered for potential for restraints during an observation of resident #001 having two bed rails in the up position located at the top half of the bed.

Review of resident #001’s assessments in Point Click Care (PCC) did not indicate resident #001 was assessed to use bed rails.

Review of resident #001’s written plan of care indicated that resident #001 required assistance for mobility and bed mobility due to identified medical conditions. The care plan indicated resident #001 directed staff to provide an identified level assistance with bed mobility and to use a bed rail.

Interview with resident #001 indicated the bed and the two bed rails belonged to him/her and that he/she used the bed rails when he/she is in bed to assist him/her to get in and out of bed.

Interview with an identified caregiver of resident #001 indicated the bed belonged to resident #001 and was brought into the home by the resident when he/she was admitted on an identified date. The caregiver indicated the two bed rails came with the bed and indicated resident #001 uses the bed rails when he/she was in bed to assist him/her to get in and out of the bed and also for security and comfort as the resident was at risk of falls.

Interview with the Physiotherapist (PT) indicated that any resident who was using a bed rail that may be considered as a restraint are assessed by him/her prior to the resident using the bed rail. He/she indicated he/she did not assess resident #001’s to use the bed rails.

Interviews with RPN #101 and RN #102 indicated there were no assessment completed

for resident #001 for bed rails since admission.

Interview with the DRS indicated it was the home’s practice that any resident who uses a bed rail must be assessed by the PT prior to having the bed rail and reassessed quarterly afterwards.

Interview with the DRS indicated that resident #001 bed and the two bed rails belonged to the resident and was brought into the home by the resident when he/she was admitted on an identified date and that the home had not completed an assessment for the resident to use the bed rails. [s. 15. (1) (a)]

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 where bed rails are used, that the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: 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 failed to protect residents from abuse and neglect

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to resident #020.

Review of an identified document addressed to home’s DNS, on an identified date

identified resident #020 joint Substitute Decision Makers (SDM) had informed the home of their concerns.

Interview with resident #020's SDM reiterated the above information as noted in the initial letter of complaint submitted to the home. The SDM identified resident #020 suffered from an identified medical condition was unable to appreciate or make competent choices, and was not protected from abuse. The SDM identified resident #020 had been discharged from the facility prior to the submission of the complaint to the MOHLTC.

Record review of resident #020's clinical records identified he/she was diagnosed with an identified medical condition. Review of resident #020's Quarterly Minimum Data Set Assessments (MDS) on two identified dates identified resident #020 to have a number of identified medical conditions. Resident #020's cognitive performance scale score remained at the assigned level in these assessments, including up to the time of discharge on an identified date.

Review of resident #020's progress notes identified multiple entries from identified dates in which the abuse had occurred.

Review of a progress note on an identified date documented by RN #109, indicated that resident #020 was redirected out of resident #021's room after staff intervention and did not attempt to go to resident #021's room thereafter.

Interviews with PSW #105 and #106 identified the residents' on the identified unit would be unable to provide or express consent due to cognitive and judgement impairments related to an identified medical condition. PSW #105 and 106 reported resident #021 was known to seek out and approach resident #020. PSW #106 identified resident #021 would lead resident #020 to his/her room, and was noted to display an identified manner in his/her pursuit of resident #020.

PSW's #105 and #106 stated that they were aware resident #020 had expressed concern related to the dynamic between resident #020 and resident #021.

Interview with RN #109 indicated residents on the identified unit were unable to express consent due to identified medical conditions. RN #109 identified he/she was aware of the concerns related to resident #021. RN #109 identified resident #021 was known to seek out resident #020. RN #109 stated resident #020 had an intervention in place to prevent resident #021 from entering but the intervention was not effective. Review of the above

noted progress notes with RN #109 acknowledged resident #021 was known to seek out resident #020. The inspector reviewed progress note documented by RN #109 on an identified date which identified resident #020 and #021 were together in an abusive manner. RN #109 acknowledged the content of the progress note as his/her documentation. Additional progress notes as noted above, were reviewed with RN #109 and indicated that staff discovered the residents in each other’s company on multiple occasions. Upon further inquiry, RN #109 was unable to demonstrate how the home's staff prevented resident #021 from seeking out resident #020.

The home's DNS reported that residents with a cognitive performance score of three or more were unable to discerningly provide expressed consent due to an identified medical condition. The DNS identified inappropriate touching of a resident and exposure to an identified intent were considered abuse. The DNS had not been actively involved during the time period during which the alleged concerns were identified related to resident #021’s advances to resident #020. The DNS was unable to speak to details regarding the home's management of the issue and identified RN #109 as the point of contact for the matter inspected.

Record review and staff interviews failed to demonstrate resident #020 had been assessed or determined to demonstrate consent to an identified type of behaviour, and that resident #020 had been protected from resident #021 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 and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that licensee that there was a written plan of care for each resident that sets out, (a) the planned care for the resident.

During stage one of the RQI, resident #006 triggered for potential in lacking dignity, choice, privacy, and choices based on a family interview related to the resident's grooming.

Interview with the SDM indicated that he/she had consented for resident #006 to have an identified grooming service and indicated that the resident had not been getting the identified grooming service.

Review of an identified document of resident #006 indicated resident #006's SDM consented for the resident to have an identified grooming service on an identified date.

Review of resident #006's written careplan did not indicate any direction for staff to ensure that resident #006 was scheduled for the identified grooming service.

Interview with PSW #100 indicated that when he/she observed that resident #006's required the identified care, the PSW indicated he/she would ask the resident if he/she wanted an identified grooming service but was not aware that resident #006 was scheduled to have his/her identified grooming services on an identified date.

Interview with RN #102 indicated that resident #006's written care plan did not indicate that the resident was to be scheduled for an identified grooming on an identified date.

Interview with DRS indicated that direction regarding an identified grooming service should be included in the resident's written careplan under the focus of grooming. [s. 6. (1) (a)]

Issued on this 28th day of November, 2017

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

Original report signed by the inspector.