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 prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 31, 2018	2018_638542_0023	030852-18	Complaint

Licensee/Titulaire de permis

The Rekai Centres (fka 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

JENNIFER LAURICELLA (542)

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): December 10 - 14, 2018.

The following log was inspected;
Log #030852-18 related to the alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Directors of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector observed the provision of care to the residents, conducted a tour of the resident care areas, reviewed resident health care records, reviewed relevant policies and procedures, and reviewed the home's complaint logs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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	Légende 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

A complaint was submitted to the Director outlining care concerns regarding resident #001. It was noted that numerous emails from the complainant were sent to the management team of the home concerning the care of resident #001.

Inspector #542 reviewed the home's received complaints for 2017 and 2018. In 2017, there were four written complaints regarding the care of residents. In 2018, there was one complaint outlining the care of a resident. Inspector #542 reviewed the Critical Incident Reports (CIS) that were submitted to the Director and noted that the above mentioned complaints were not submitted to the Director.

Inspector #542 was approached by resident #002's family member who indicated that they submitted a complaint to the home's management team regarding the care of resident #002 and the operations of the home. Inspector #542 reviewed the Critical Incident Reports (CIS) that were submitted to the Director and noted that the above mentioned complaint was not submitted to the Director.

A review of the home's policy, titled, "Client Service Response" indicated that any written correspondence that outlined concerns will be identified as a complaint and will be forwarded to the Ministry of Health and Long-Term Care within 10 business days.

Inspector #542 interviewed the Executive Director, who indicated that the home had not forwarded these written complaints to the Director and that the home's policy was incorrect. [s. 22. (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 a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, 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 that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was 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 risk of harm to the resident.

Inspector #542 reviewed the home's complaint logs for 2017, and located a complaint of alleged abuse from June, 2017. It was documented that resident #003 had reported to a staff member that a PSW had provided them with assistance and was very rough and resentful to assist the resident. Resident #003 was emotional, in tears and upset at the way the PSW treated them. Furthermore, under the section, "recommended action" it was documented that the staff member was met with to discuss the home's mandate for zero tolerance of abuse.

Inspector #542 reviewed the home's policy, titled, "Abuse or Neglect" dated March 2016. It was documented that, when becoming aware of abuse or neglect, suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Director.

Inspector #542 interviewed Director of Care #102 who indicated that they did not report this to the Director because, when interviewed, resident #003 could not recall the event.

Inspector #542 interviewed the home's Executive Director, who indicated that this incident should have been reported to the Director. [s. 24. (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 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 risk of harm to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

A complaint was submitted to the Director outlining concerns regarding the care of resident #001. The complainant indicated that resident #001 developed an area of altered skin integrity within weeks of admission to the home.

A review of the home's Skin Care and Wound Management Program indicated that a "head to toe" skin assessment was to be completed within 24 hours of admission by a member of the registered staff.

Inspector #542 reviewed the health care records for resident #001. A review of the

paper and electronic documentation on PointClickCare (PCC) was completed. Inspector #542 was unable to locate a head to toe assessment that was completed within 24 hours of admission. The first completed head to toe assessment was completed 16 days after admission.

Inspector #542 reviewed resident #001's initial plan of care which indicated that they had the potential for skin integrity issues or pressure ulcers.

Inspector #542 interviewed RN #105 regarding resident #001's altered skin integrity. They indicated that a 24 hour head to toe assessment was to be completed within 24 hours of an admission. RN #105 verified that this was not completed for resident #001.

Inspector #542 interviewed Director of Care (DOC) #102 who was unable to locate a head to toe skin assessment that was completed for resident #001 within 24 hours of admission. [s. 50. (2) (a) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #542 was approached by resident #002's family member as they had concerns regarding the provision of care. The family member indicated that resident #002 had an area of altered skin integrity and that they had been completing the wound treatments as they felt that the home was not completing the treatment properly.

Inspector #542 reviewed resident #002's progress notes on PointClickCare (PCC). It was documented that the area of altered skin integrity had healed however it had started to deteriorate in the spring of 2017. A review of the wound assessments located on PCC indicated that the next assessment of the area was completed nine months later. The following assessment was completed 14 days later and the next assessment was completed 19 days later.

Inspector #542 reviewed the home's Skin Care and Wound Management Program which indicated that the registered staff were to document the progress of the wound and the effectiveness of the treatment weekly.

Inspector #542 interviewed RN #105, who was the Skin and Wound lead. They confirmed that the weekly wound assessments were not being completed and that they

should have been. [s. 50. (2) (b) (iv)]

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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (i) within 24 hours of the resident's admission and that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, a) the nature of each verbal or written complaint, b) the date the complaint was received, c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, d) the final resolution, if any, e) every date on which any response was provided to the complainant and a description of the response, and, f) any response made by the complainant.

A complaint was submitted to the Director, outlining care concerns regarding resident #001.

Inspector #542 reviewed the home's complaint logs for 2017 and 2018 and a summary of the written complaints. The document included written complaints; however, there was no mention of any verbal complaints.

Inspector #542 interviewed the Executive Director and reviewed O. Reg 79/10, r. 101. (2) which outlined how the home was to deal with verbal or written complaints. The Executive Director indicated that the home had not been keeping a documented record of any verbal complaints. [s. 101. (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 that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A complaint was submitted to the Director outlining concerns regarding the home's infection prevention and control program.

Inspector #542 was informed by the home's management team that they were in an outbreak due to a reportable communicable disease, and that several units were affected.

Inspector #542 observed two staff members wearing gloves and one staff member wearing an isolation gown in the dining room during the lunch service, on the fourth floor, in the east home area. Inspector observed the staff to be feeding some of the residents while wearing Personal Protective Equipment (PPE). The staff were observed to be going from resident to resident without removing their gloves or gown and without performing hand hygiene. Inspector #542 also observed staff removing soiled dishes and then handling resident's clean dishes without performing hand hygiene.

Inspector #542 interviewed PSW #106 regarding the use of the isolation gown in the dining room during the lunch service. PSW #106 indicated that they were entitled to wear the isolation gown in the dining room as some of the residents had a reportable communicable disease. Inspector #542 then observed PSW #106, providing feeding assistance to numerous residents without removing the PPE and without performing hand hygiene.

Inspector #542 interviewed RN #108, who indicated that it was not encouraged for staff to wear PPE during the lunch service and that PPE should be worn during direct care and feeding was not considered direct care.

Inspector #542 interviewed DOC #101 who indicated that wearing PPE in the dining room was not advisable and that they were to remove the PPE when moving from one

resident, to another.

A review of the home's policy, titled, "Routine Practices" dated, 2018, indicated that hand hygiene was to be performed immediately after the removal of gloves. It was also documented in the policy that gloves were not required for routine resident care activities such as feeding and that gowns were to be worn during procedures and resident care activities that would generate splashes or sprays. Both items were to be removed after the activity. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 2nd day of January, 2019

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

Original report signed by the inspector.