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
Jun 4, 2019	2019_616722_0010	010762-18, 024946-18, 003430-19, 005859-19	Critical Incident System

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

COREY GREEN (722), MELISSA HAMILTON (693)

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): May 13-17, 2019.

During this inspection, the following critical incidents (CI) were inspected:
- Three (3) critical incidents related to falls.
- One (1) critical incident related to abuse.

PLEASE NOTE: Non-compliance related to LTCHA, 2007, c.8, s. 24 (1), was identified in this inspection and has been issued in Inspection Report 2019_616722_0009, dated June 4, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, resident family members, personal support workers (PSWs), registered practical nurses (RPNs), registered nurses (RNs), and the Director of Resident Care (DRC).

The inspectors also made observations of residents and resident home areas; reviewed administrative records and policies; and reviewed resident health records.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #005 sustained a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A critical incident (CI) report was submitted to the Director on a specified date, which identified that resident #005 had sustained a fall resulting in a specified injury.

Inspector #693 reviewed the progress notes for resident #005 in PointClickCare (PCC), the electronic health record. A progress note on a specified date, composed by RN #113, indicated that resident #005 sustained a fall in a specified location, and PSW #110 was present.

During an interview with Inspector #693, PSW #110 stated that when resident #005 sustained the fall, they immediately informed RN #113. The PSW indicated that the RN was responsible for ensuring a post-fall assessment was completed.

Inspector #693 reviewed the health records for resident #005, and was unable to identify a post-fall assessment for the resident's fall on the specified date.

The Director of Resident Care (DRC) provided Inspector #693 a copy of the home's "Quality Management, Post Fall Assessment Policy", last revised July, 2018. The policy indicated that all residents were to be assessed after sustaining a fall, with a tool specifically designed to determine the extent and type of injury, as well as any contributing factors that may have caused the fall. The policy indicated that residents were to be assessed after each fall using the Risk Incident Assessment specific to falls in PCC.

During an interview with Inspector #693, RN #111 indicated that they were the Falls Lead for the home. They stated that when a resident had fallen, as part of the home's Falls Prevention Program, registered staff members were expected to complete a post fall Risk Incident Assessment using the electronic tool available in PCC. RN #111 was unable to identify the post fall assessment in PCC for resident #005's fall on the specified date, and indicated that it should have been completed at the time of the fall.

The licensee failed to ensure that a post-fall assessment was conducted for resident #005 after their fall, that resulted in an injury, on the specified date. [s. 49. (2)]

Issued on this 14th day of June, 2019

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

Original report signed by the inspector.