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
Jun 4, 2019	2019_616722_0009	010483-18, 010514-18, 000305-19, 003186-19	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

COREY GREEN (722), MELISSA HAMILTON (693)

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): May 13-17, 2019.

The following complaints were inspected during this inspection:
- One (1) complaint related to an allegation of abuse.
- Two (2) logs related to allegations of abuse, personal support services, meal service, skin and wound care, and the complaints process.

A critical incident was inspected concurrently during this inspection, as it related to one of the complaints above.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 24 (1), identified in concurrent inspection #2019_616722_0010, were issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, resident family members, personal support workers (PSWs), dietary aides (DAs), registered practical nurses (RPNs), registered nurses (RNs), the Food Services Manager (FSM), the Resident and Family Services Coordinator (RFSC), the Director of Resident Care (DRC), and the Administrator.

The inspectors also made observations of residents and resident homes areas (RHAs), including staff-to-resident and resident-to-resident interactions; reviewed administrative records, including relevant policies and training records; and reviewed electronic and hard-copy clinical health records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
1 VPC(s)
1 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. 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 failed to ensure that a staff member who had reasonable grounds to suspect that abuse of resident #002 had occurred, that resulted in harm or a risk of harm to the resident, reported the suspicion and the information upon which it was based to the Director.

A critical incident (CI) report was received by the Director on a specified date, related to an incident of abuse that involved resident #002 and occurred on the same day the CI report was submitted.

Inspector #722 reviewed the progress notes for resident #002, and identified an entry by RPN #106, submitted prior to the CI report identified above, which indicated that resident #002 stated that a specified person had behaved towards them in an abusive manner. The note indicated that the RN in charge was notified. No other progress notes were identified related to this incident.

RPN #106 confirmed during an interview with Inspector #722 that they had created the progress note on the specified date. The RPN described being aware of a pattern of specified behaviour between the identified person and resident #002. The RPN

confirmed that they notified the RN in charge. The RPN also indicated that they were expected to report the incident to the charge nurse, and that management would follow-up.

PSW #120 indicated in an interview with Inspector #722 that they had observed the specified person intoxicated while in the home visiting resident #002. The PSW described an ongoing pattern of behaviour by the identified person toward resident #002; and acknowledged that the identified person had been observed being abusive toward the resident. The PSW indicated that management were aware, and had escorted the identified person out of the home on several occasions.

The home's CI reports were reviewed by Inspector #722; no CI reports were identified related to this allegation of abuse involving resident #002 and the identified person on the date that the RPN made the progress note entry described above.

Inspector #722 reviewed the home's "Abuse or Neglect Policy" (Index ID: P-10), revised December 20, 2018, which indicated the following:
- Staff had a moral and legal obligation to report any incident or suspected incident of resident abuse and neglect;
- The home had zero tolerance for abuse or neglect, and all allegations of abuse and neglect would be promptly reported; and
- On becoming aware of abuse or neglect, suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Director at the MOHLTC, the Administrator, or if not available, the Director of Nursing or Delegate.

During an interview with the Director of Resident Care (DRC), Inspector #722 reviewed the entry in the progress notes detailed above. The DRC indicated that they had no knowledge of the incident; and the charge RN should have notified the Director of Nursing Services (DNS) or DRC about the incident, so that it could have been investigated and reported. The DRC confirmed that a CIS report was not submitted to the Director, and an investigation was not initiated by the management team, related to this allegation of abuse, and that it should have been according to the home's abuse prevention policy. [s. 24. (1)]

2. The licensee failed to ensure that a staff person, who had reasonable grounds to suspect that resident #003 may have been abused by resident #004, an incident which resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Director on a specified date, which indicated that resident #004 frequently attempted to enter resident #003's room, and attempted to be abusive toward them. A second complaint regarding this issue was received by the Director on a later specified date.

Inspector #722 interviewed both complainants by telephone prior to the inspection. Both complainants indicated during the interview that the Resident and Family Services Coordinator (RFSC) was notified about the behaviour by resident #004 toward resident #003. One of the complainants also indicated that these incidents caused resident #003 distress and had lasting specified impacts.

The home's CI reports were reviewed by Inspector #722 during the period that resident #003 resided in the home; no CI reports were identified related to an allegation of abuse involving resident #004 toward resident #003.

Review of the progress notes for both residents indicated that during a specified period, resident #004 frequently attempted to gain entry to resident #003's room, and behaved in a specified manner toward the resident. A progress note for resident #004, entered on a specified date by RN #117, indicated that they were concerned about resident #004 wandering into resident #003's room and behaving in a specified manner toward the resident.

RN #117 and PSW #122 were separately interviewed by Inspector #722, and both confirmed that resident #004 regularly attempted to enter resident #003's room, and would attempt to act in a specified manner toward resident #003; however, neither staff member recalled seeing resident #004 act in an identified abusive manner toward resident #003.

Inspector #722 interviewed the RFSC, who indicated that one of the specified complainants had reported to them that resident #004 was behaving in a specified abusive manner toward resident #003. The RFSC could not recall the exact date that the complainant made the allegation, but indicated that it was likely during an identified period soon after resident #003 was admitted to the home. The RFSC indicated that they had not submitted a CI report to the Director about this allegation of abuse. The RFSC acknowledged that the expectation was that the allegation should have been reported to the DNS or DRC, who were responsible for submitting CI reports related to abuse.

The DRC indicated during an interview with Inspector #722 that the expectation was that the RFSC, who was a member of the home's management team, should have notified the DNS (or DRC in their absence) of this allegation of abuse involving resident #003. The DRC indicated that a CI report should have been submitted to the Director for this allegation, and confirmed that it was not submitted as required. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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 failed to ensure, for a verbal complaint from a family member made to various staff members in the home, concerning the care of resident #003, that:
(A) Where the complaint alleged harm or risk of harm to the resident, that the investigation was commenced immediately; and,
(B) For a complaint that could not be investigated and resolved within 10 business days, that an acknowledgement of receipt of the complaint was provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response provided as soon as possible in the circumstances; and
(C) A response was made to the person who made the complaint, which indicated, i. what the licensee had done to resolve the complaint, or ii. that the licensee believed the complaint was unfounded and the reasons for the belief.

A complaint was received by the Director on a specified date, concerning identified behaviours involving resident #004 toward resident #003; this complainant was directly involved in the care of resident #003 and is the complainant that raised concerns to the home as described below.

The complainant explained during an interview with Inspector #722 that resident #004 persistently behaved in a specified problematic manner toward resident #003, and that

the behaviours caused resident #003 distress and other identified long-term impacts. The complainant indicated that they spoke with registered staff on the unit, as well as the RFSC and DNS, on numerous occasions about their concerns. The complainant indicated that management in the home notified them that there was nothing they could do, aside from a specified action that was never implemented, and stated that their concern was never resolved. The SDM stated that they never received any notifications or responses from the home related to their concerns, and that their concerns were not resolved as long as resident #004 resided in the unit with resident #003.

Inspector #722 reviewed the progress notes for resident #003, over a specified period, and several notes by RN #117 were identified that described the problematic behaviours of resident #004 toward resident #003, and demonstrated that the complainant had raised their concerns to the registered staff. One entry specified that RN #117 had notified the RFSC about the ongoing issues involving resident #004; another entry identified that the RN had notified the DRC about the complainant's concerns. The progress notes were also reviewed for resident #004, over a specified period, and eight (8) entries were identified where the problematic behaviour by resident #004 toward resident #003 was described.

RN #117, a charge nurse in the unit where both residents resided, indicated during an interview with Inspector #722 that resident #004 specifically targeted resident #003; the problematic behaviours by the co-resident started soon after resident #003 was admitted to the home; and the behaviours occurred on a daily basis, often multiple times each day. RN #117 indicated that resident #004's problematic behaviours toward resident #003 continued until resident #004 was discharged from the unit.

RN #117 indicated that the complainant notified them of their concerns within the first few weeks after resident #003 was admitted to the unit, and frequently voiced concerns related to resident #004s behaviours toward resident #003. RN #117 indicated that they were aware that the complainant was frustrated, and noted that they had also brought up their concerns at resident #003's care conference. RN #117 indicated that they had spoken with the DRC about the complainant's concerns, and that the RFSC was also involved in discussions about possible solutions. RN #117 stated that the complainant's concerns were never resolved, as long as resident #004 was residing in the same unit as resident #003, and indicated that the expectation in the home was that if a complaint/concern could not be resolved right away, that management must be notified and involved.

During an interview with Inspector #722, the RFSC indicated that the complainant had notified them about their concerns related to resident #004's problematic behaviours toward resident #003 soon after the resident was admitted to the home. The RFSC indicated that they had spoken with the complainant on numerous occasions in their office; and acknowledged that the complainant had informed them that resident #004's behaviours were causing resident #003 distress. The RFSC indicated that the management team had proposed a specified solution, and stated that the complainant was not satisfied with the proposed solution; the RFSC acknowledged that the complainant's concerns were not resolved as long as resident #003 resided in the same unit as resident #004.

During the interview, the RFSC indicated that they did not initiate an investigation related to the complainant's concerns, as that was the responsibility of the DNS/DRC. The RFSC stated that they did not take any notes during their meetings with the complainant, and did not have any documentation related to their complaint. When requested by Inspector #722, the RFSC was unable to provide any records that indicated when they spoke with the complainant, that the complaint was investigated and resolved, that a response was provided within ten (10) business days of receipt of the complaint, or that an investigation was commenced immediately.

The RFSC also indicated that they were responsible for managing complaints in the home, and confirmed that they did not make an entry in the home's complaints log, did not complete the Client Services Response (CSR) form, and did not provide any written notifications or responses to the complainant related to their complaint. The RFSC acknowledged during the interview that they did not follow the home's CSR policy for addressing this complaint.

The home's policy, Client Service Response, Code #E-42, last reviewed November 2018, indicated:
- All concerns/complaints were to be documented and followed up;
- Where complaints could not be resolved within 24 hours, a written record of the complaint as well as the investigation of the outcome should be retained by the home;
- All concerns/complaints were to be addressed within 10 business days; and
- Corrective actions were to be taken and a response was to be given to any concern/complaint that was raised.

Inspector #722 interviewed the DRC, who acknowledged that they were aware that resident #004 continued to exhibit specified problematic behaviours toward resident

#003, and that the staff on the floor, the DNC, and RFSC were in discussions with the complainant concerning the issue. The DRC confirmed that there was no written documentation related to this complaint, including documentation that indicated that the complaint was investigated. The DRC confirmed that no written responses were provided to the complainant at any time related to this complaint. The DRC explained that the expectation was that the complaint should have been entered in the home's complaints log, a CSR form should have been completed, and responses provided in writing to resident #003's SDM; they acknowledged that the home did not follow their Client Services Response policy for this complaint involving resident #003. [s. 101. (1) 3.]

2. The licensee failed to ensure that a documented record was kept in the home related to the complaint received involving resident #003, that included, (a) the nature of the complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint; (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.

See WN #2-1 above for details related to this complaint.

The RFSC confirmed during the interview with Inspector #722 that they met numerous times with the complainant related to their concerns involving problematic behaviours by resident #004 toward resident #003. The RFSC acknowledged that they did not have any written documentation of the meetings, and could not provide any specific dates or details about what was discussed at any of the meetings. The RFSC also indicated that they were responsible for the complaints process in the home, and had not entered the complaint in the complaint log, or completed the CSR form, which would have captured the information about type of complaint, when it was received, by whom, recommended action, actions taken, and family response. The RFSC acknowledged that they did not follow the home's complaint policy, and did not document any aspects of the complaint from the complainant.

The licensee's policy, Client Service Response (CSR), Code #E-42, last reviewed November 2018, indicated the following:
- All concerns/complaints were to be documented and followed up;
- For complaints that could not be resolved within 24 hours, a written record of the complaint as well as the investigation of the outcome should be retained by the home; and
- All complaints were to be traced for internal quality improvement purposes; and

- Once a complaint was received, a CSR form was to be initiated by staff and sent to the RFSC or designate.

Inspector #722 interviewed the DRC, who acknowledged that there was no documentation available related to the complaint involving resident #003, and that documentation was required according to the home's complaint policy. The DRC indicated that the expectation was that the complaint should have been logged and a CSR form initiated to meet the documentation requirements. [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) Every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as detailed in O. Reg. 79/10, s. 101 (1), paragraphs 1, 2, and 3; and,

(B) A documented record is kept in the home that includes all items specified in O. Reg. 79/10, s. 101 (2), clauses (a) to (f)., to be implemented voluntarily.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan.

A critical incident (CI) report and complaint were received on a specified date, related to an allegation of staff to resident abuse involving resident #001. It was alleged that

resident #001 sustained identified injuries while being assisted by PSW #109.

Inspector #722 reviewed the clinical records for resident #001, which indicated that the resident had specified responsive behaviours. A number of interventions were specified in the care plan related to the resident's responsive behaviours.

Inspector #722 reviewed the investigation notes related to this incident, and identified a typed statement that was signed and dated by PSW #109. In the statement, the PSW described that they attempted to provide specified assistance on an identified date, the resident was exhibiting specified responsive behaviours, and the PSW went to inform another PSW. The statement indicated that the other PSW advised PSW #109 to provide encouragement and continue to assist the resident with their care; PSW #109 proceeded to assist the resident with specified care, as the resident continued to demonstrate the specified responsive behaviours.

Inspector #722 reviewed the home's policy, "Care Plans", Index ID: C-15, revised July 30, 2018, which indicated the following under Procedure: 6. It is the responsibility of the registered staff to ensure that care plans reflect each resident's current condition, strengths, abilities, risks, likes and dislikes and that the staff assigned to those residents are aware of the specific direction/intervention needed to meet resident's individual needs.

Inspector #722 interviewed RN #113 and PSW #110, separately, who both acknowledged that resident #001 had specified responsive behaviours that were identified in the statement by PSW #109. Both staff members verified that resident #001's care plan identified a number of specified interventions related to their responsive behaviours.

During an interview with Inspector #722, the DRC reviewed the investigation notes and typed statement signed by PSW #109, and acknowledged that PSW #109 did not implement a number of specified interventions in resident #001's plan of care for managing the resident's responsive behaviours. The DRC also indicated that PSW #109 should have notified the registered staff on duty that the resident was demonstrating the responsive behaviours, and they should have requested that another PSW join them in providing resident #001 with the specified care.

The DRC confirmed that PSW #109 had not provided care to resident #001 related to their responsive behaviours, as specified in the resident's plan of care; and indicated that

the PSW should not have proceeded to provide the specified care to resident #001 on their own, when the resident had demonstrated the specified responsive behaviours. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that on specified dates and meal times, the planned menu items were offered and available at each meal in a specified dining room.

A complaint was received on a specified date, which indicated that while sitting with their family member in the identified dining room, they observed another resident that was not provided a meal during the meal service.

Inspector #722 made observations of the dining room during several meal services, and observed the following:

On a specified date, during a meal service, the posted daily menu indicated assorted juice, cream of wheat (or assorted cold cereal), cheddar cheese (or scrambled eggs), raisin toast, and banana (or fresh orange slices). Inspector #722 observed that the majority of residents were served whole wheat toast, hard-boiled eggs, and fruit yoghurt. During an interview with Inspector #722, Dietary Aide (DA) #116 indicated that there was no cheddar cheese, raisin bread, or bananas offered or available at this meal service, and acknowledged that the daily menu posted did not reflect the food that was served. DA #116 indicated that they were out of bananas, and that they usually provided the residents hard boiled eggs, even when scrambled eggs were on the menu.

On a different specified date, during another meal service, the posted daily menu indicated assorted beverages, chicken soup, Mediterranean frittata with focaccia and baked tomato (or hot dog on a bun with tossed salad), and pineapple (or butterscotch pudding). Inspector #722 observed that the residents were served cream of carrot soup,

pastrami sandwich with rainbow garden salad and dill pickle spear (or three cheese pizza with herbed zucchini), and mango (or brownie). PSW #123 acknowledged in an interview with Inspector #722 that the posted daily menu was not correct, and did not match the food that was being served.

The Food Service Manager (FSM) was interviewed by Inspector #722, who indicated that the daily menu posted in each dining room should reflect the food served at each meal (breakfast, lunch, and dinner) on that day. The FSM confirmed that the menu posted in the specified dining room during the meal services, were the incorrect daily menus.

The DRC also acknowledged during an interview with Inspector #722 that the expectation was that the planned menu items were offered and available at each meal, and that this was not the case on the dates and meal services as specified above. [s. 71. (4)]

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.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COREY GREEN (722), MELISSA HAMILTON (693)
Inspection No. / No de l'inspection :	2019_616722_0009
Log No. / No de registre :	010483-18, 010514-18, 000305-19, 003186-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 4, 2019
Licensee / Titulaire de permis :	The Rekai Centres (fka Drs. Paul and John Rekai Centre) 345 Sherbourne Street, TORONTO, ON, M5A-2S3
LTC Home / Foyer de SLD :	Wellesley Central Place 160 Wellesley Street East, TORONTO, ON, M4Y-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dwayne Wyrwas

To The Rekai Centres (fka Drs. Paul and John Rekai Centre), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall be compliant with s. 24 (1) of the Long term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

a) Ensure that all employees who have witnessed or suspect that a resident is being abused or neglected immediately report the allegations as per the home's policy; and,

b) Develop and implement a process to ensure that staff are aware and understand what constitutes a suspicion of abuse, and that they must report it immediately.

All records pertaining to b) above must be maintained, including staff signatures for participation in any re-training activities, and provided to the inspector upon request during the follow-up inspection.

Grounds / Motifs :

1. The licensee failed to ensure that a staff member who had reasonable grounds to suspect that abuse of resident #002 had occurred, that resulted in

harm or a risk of harm to the resident, reported the suspicion and the information upon which it was based to the Director.

A critical incident (CI) report was received by the Director on a specified date, related to an incident of abuse that involved resident #002 and occurred on the same day the CI report was submitted.

Inspector #722 reviewed the progress notes for resident #002, and identified an entry by RPN #106, submitted prior to the CI report identified above, which indicated that resident #002 stated that a specified person had behaved towards them in an abusive manner. The note indicated that the RN in charge was notified. No other progress notes were identified related to this incident.

RPN #106 confirmed during an interview with Inspector #722 that they had created the progress note on the specified date. The RPN described being aware of a pattern of specified behaviour between the identified person and resident #002. The RPN confirmed that they notified the RN in charge. The RPN also indicated that they were expected to report the incident to the charge nurse, and that management would follow-up.

PSW #120 indicated in an interview with Inspector #722 that they had observed the specified person intoxicated while in the home visiting resident #002. The PSW described an ongoing pattern of behaviour by the identified person toward resident #002; and acknowledged that the identified person had been observed being abusive toward the resident. The PSW indicated that management were aware, and had escorted the identified person out of the home on several occasions.

The home's CI reports were reviewed by Inspector #722; no CI reports were identified related to this allegation of abuse involving resident #002 and the identified person on the date that the RPN made the progress note entry described above.

Inspector #722 reviewed the home's "Abuse or Neglect Policy" (Index ID: P-10), revised December 20, 2018, which indicated the following:
- Staff had a moral and legal obligation to report any incident or suspected incident of resident abuse and neglect;

- The home had zero tolerance for abuse or neglect, and all allegations of abuse and neglect would be promptly reported; and
- On becoming aware of abuse or neglect, suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Director at the MOHLTC, the Administrator, or if not available, the Director of Nursing or Delegate.

During an interview with the Director of Resident Care (DRC), Inspector #722 reviewed the entry in the progress notes detailed above. The DRC indicated that they had no knowledge of the incident; and the charge RN should have notified the Director of Nursing Services (DNS) or DRC about the incident, so that it could have been investigated and reported. The DRC confirmed that a CIS report was not submitted to the Director, and an investigation was not initiated by the management team, related to this allegation of abuse, and that it should have been according to the home's abuse prevention policy. [s. 24. (1)] (722)

2. The licensee failed to ensure that a staff person, who had reasonable grounds to suspect that resident #003 may have been abused by resident #004, an incident which resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Director on a specified date, which indicated that resident #004 frequently attempted to enter resident #003's room, and attempted to be abusive toward them. A second complaint regarding this issue was received by the Director on a later specified date.

Inspector #722 interviewed both complainants by telephone prior to the inspection. Both complainants indicated during the interview that the Resident and Family Services Coordinator (RFSC) was notified about the behaviour by resident #004 toward resident #003. One of the complainants also indicated that these incidents caused resident #003 distress and had lasting specified impacts.

The home's CI reports were reviewed by Inspector #722 during the period that resident #003 resided in the home; no CI reports were identified related to an allegation of abuse involving resident #004 toward resident #003.

Review of the progress notes for both residents indicated that during a specified period, resident #004 frequently attempted to gain entry to resident #003's room, and behaved in a specified manner toward the resident. A progress note for resident #004, entered on a specified date by RN #117, indicated that they were concerned about resident #004 wandering into resident #003's room and behaving in a specified manner toward the resident.

RN #117 and PSW #122 were separately interviewed by Inspector #722, and both confirmed that resident #004 regularly attempted to enter resident #003's room, and would attempt to act in a specified manner toward resident #003; however, neither staff member recalled seeing resident #004 act in an identified abusive manner toward resident #003.

Inspector #722 interviewed the RFSC, who indicated that one of the specified complainants had reported to them that resident #004 was behaving in a specified abusive manner toward resident #003. The RFSC could not recall the exact date that the complainant made the allegation, but indicated that it was likely during an identified period soon after resident #003 was admitted to the home. The RFSC indicated that they had not submitted a CI report to the Director about this allegation of abuse. The RFSC acknowledged that the expectation was that the allegation should have been reported to the DNS or DRC, who were responsible for submitting CI reports related to abuse.

The DRC indicated during an interview with Inspector #722 that the expectation was that the RFSC, who was a member of the home's management team, should have notified the DNS (or DRC in their absence) of this allegation of abuse involving resident #003. The DRC indicated that a CI report should have been submitted to the Director for this allegation, and confirmed that it was not submitted as required. [s. 24. (1)]

The severity of this issue was determined to be a level 2, as there was minimal harm to both residents involved. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 3 history of previous non-compliance to the same subsection of the LTCHA, 2007, that included:
- Written notification (WN) issued January 27, 2017 (2016_356618_0023); and
- Voluntary plan of correction (VPC) issued December 31, 2018

(2018_638542_0023); and January 27, 2017 (2016_356618_0024). (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 04, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Corey Green

Service Area Office /
Bureau régional de services : Toronto Service Area Office