Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 1, 2021	2021_563670_0011	024498-20, 005274-21, 005477-21, 006389-21, 006581-21	Critical Incident System

Licensee/Titulaire de permis

The Rekai Centres
160 Wellesley Street East Toronto ON M4Y 1J2

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

DEBRA CHURCHER (670), KRISTEN MURRAY (731)

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 25, 26, 27 and 28, 2021.

The purpose of this inspection was to inspect the following:
-Log#005477-21 CIS# 2959-000005-21 related to fall with injury.
-Log#006581-21 CIS# 2959-000007-21 related to fall with injury.
-Log#006389-21 CIS# 2959-000006-21 related to fall with injury.
-Log#024498-20 CIS# 2959-000005-20 related to alleged improper treatment of a resident.
-Log#005274-21 CIS# 2959-000004-21 related to an injury of unknown origin.
Inspector #730 Christy Legouffe was also present for this inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Executive Director, the Director of Nursing Services, the Acting Director of Resident Care, two Registered Nurses, three Personal Support Workers, three Registered Practical Nurses and residents.

During the course of this inspection the Inspectors observed the overall cleanliness and maintenance of the home, observed staff to resident interactions, observed the provision of care, observed infection prevention and control practices, reviewed relevant resident clinical records, reviewed relevant internal records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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)

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. 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 that the care set out in the plan of care was provided to a resident as specified in the plan.

Review of a resident's plan of care interventions related to a specific activity of daily living (ADL) showed that a resident required use of a specific type of medical equipment.

A progress note dated for a specific date, stated that two Personal Support Workers had reported that they had not utilized the specific medical equipment when assisting the resident.

During an interview with the Director of Resident Care (DRC) they acknowledged that staff did not follow the plan of care for a resident.

The home's failure to follow the plan of care placed a resident at risk for injury.

Sources: A resident's clinical record and interview with the DRC. [s. 6. (7)]

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 that the care set out in the plan of care is provided to resident's as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure the policies related to falls management were complied with, for resident #001, and #003.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's policies and procedures "Fall Prevention Program", last revised January 2020. The fall prevention program and policy required staff to complete a head injury routine when a resident could have potentially sustained a head injury.

Resident #001 experienced an incident that resulted in a potential head injury and a head injury routine was initiated. The resident required a head injury routine and the head injury routine was not fully completed and the documentation indicated the resident was sleeping.

Resident #003 experienced an incident the resulted in a potential head injury and an intervention was initiated. The resident required a head injury routine and the head injury routine was not fully completed and the documentation indicated the resident was sleeping.

Acting Director of Resident Care (DRC) stated that a head injury routine is completed when a resident could have potentially sustained a head injury.

The Executive Director acknowledged that it was the expectation that any resident that could have potentially sustained a head injury would have a head injury routine completed even if the resident was sleeping.

The homes failure to complete the Head Injury Routines for resident #001 and #003 as per policy placed resident #001 and #003 at risk for harm.

Sources: "Fall Prevention Program", (last revised January 2020), "Head Injury Routine", number E-35 (last revised July 2019); resident #001 and 003's progress notes and head injury routine documentation; and interviews with Acting DRC and other staff. [s. 8. (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 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions with respect to the resident.

A progress note stated that a resident had two specific symptoms at a specific time, four hours later the resident experienced a specific symptom and that the Physician was emailed. A progress note for the same date stated that six hours and fifteen minutes after the resident experienced the initial symptoms the resident experienced four specific symptoms that required a transfer to the hospital. A progress note dated for the same date, twelve hours and fourty four minutes after the resident experienced the initial symptoms stated that the resident was being treated in the hospital.

During an interview with the Executive Director they stated that the physician should have been called when the resident experienced the initial symptoms so that the physician could participate in the residents plan of care.

The homes failure to notify the physician of the resident's condition placed the resident at risk of harm.

Sources: A resident's clinical record and interview with ED. [s. 26. (3) 18.]

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 resident's plan of care are based on, at a minimum, interdisciplinary assessment
of special treatments and interventions with respect to the resident, to be implemented voluntarily.

WN #4: 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 residents #002, #003 and #005 had experienced a fall, a post fall assessment was conducted using a clinically appropriate assessment instrument.

On a specific date, resident #002 experienced a fall and a post fall assessment was not completed for the resident.

On a specific date, resident #003 experienced a fall and a post fall assessment was not completed for the resident.

On a specific date, resident #005 experienced a fall and a post fall assessment was not completed for the resident.

The home's fall prevention policy required a member of the registered nursing staff to complete a post fall assessment after a resident experiences a fall.

The Acting Director of Resident Care (DRC) stated that when a resident experienced a fall a post fall assessment is to be completed in PointClickCare (PCC). The Acting DRC confirmed that post fall assessments were not completed for resident #002, #003, and #005, and they should have been.

The homes failure to complete post fall assessments placed resident #002, #003 and #005 at risk of harm.

Sources: "Fall Prevention Program", (last revised January 2020); resident #002, #003 and #005's progress notes and assessments; and interviews with the Acting DRC and other staff. [s. 49. (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 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, to be implemented voluntarily.

WN #5: 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

The home submitted a Critical Incident Report (CIS) on the seventh day of a specific month with a CIS date of the second day of the previous month related to alleged improper/incompetent treatment of a resident.

On May 27, 2021 during an interview with the Executive Director (ED), the ED stated that they had just recently started in their role at the time of the incident and were not familiar with CIS reporting at that time. The ED stated that they recognized that the report was not submitted when required.

The homes failure to report the incident in the required time frame did not pose a risk to the resident.

Sources: CIS #2959-000005-20 and interview with the ED. [s. 24. (1)]

Issued on this 2nd day of June, 2021

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

Original report signed by the inspector.