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

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Original Public Report

Report Issue Date September 13, 2022
Inspection Number 2022_1442_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Rekai Centres

Long-Term Care Home and City
Wellesley Central Place, Toronto

Lead Inspector
Wing-Yee Sun (708239)

Inspector Digital Signature
Wing Yee Sun
2022.09.26 09:58:27 -04'00'

Additional Inspector(s)
Inspector Rajwinder Sehgal (741673) and Inspector Babitha Shanmuganandapala (673) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 9-12, and 25 (off-site), 2022.

The following intake(s) were inspected:

- Intake #011842-22 (Complaint) related to continence care, alleged verbal abuse, resident personal belongings, and recreational and social activities.

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Recreational and Social Activities
- Resident Care and Support Services

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (7) 11

(i) The licensee has failed to ensure staff performed hand hygiene as required by Routine Practices.

The licensee failed to implement measures in accordance with the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC Lead failed to implement a hand hygiene program that ensured staff performed hand hygiene before and after resident/resident environment contact as required by Additional Requirements 9.1 under the IPAC Standard.

Rationale and Summary

A Personal Support Worker (PSW) was observed exiting a resident room while wearing one glove. The PSW did not remove the glove before entering another resident's room. The PSW touched a cup in the second resident's room before removing the glove. The PSW entered a third resident's room and brought them to the dining room in their mobility device. The PSW went to a fourth resident at the nursing station and brought them to the dining room in their mobility device. The PSW did not perform hand hygiene between their contact with these four residents or their environment.

The home's policy titled "Hand Hygiene" directed staff to perform hand hygiene before and after contact with the resident or their environment.

The PSW acknowledged they did not perform hand hygiene between their interaction with the four residents. Registered Practical Nurse (RPN)/IPAC Lead acknowledged the PSW did not perform hand hygiene according to the home's policy which outlined the four moments of hand hygiene.

Failure of staff to perform hand hygiene between contact with residents or their environment increased the risk of transmission of infection.

Sources: Observations in the home area, the home's policy titled "Hand Hygiene" Index I.D. IFC H-15 last revised date: April 2022, and interviews with a PSW and RPN/IPAC Lead.

(ii) The licensee has failed to ensure that residents were assisted with hand hygiene prior to meal service.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the IPAC Lead failed to implement a hand hygiene program that ensured residents were supported to perform hand hygiene prior to meals as required by Additional Requirements 9.1 under the IPAC Standard.

Rationale and Summary

Three residents were observed entering the dining room. One resident was ambulating with a mobility device and assisted by a PSW to their table. A second resident came independently to the dining room, and a third resident was assisted by their private caregiver. Staff did not assist the residents with performing hand hygiene upon entry to the dining room. These residents were observed eating and drinking independently.

The home's policy titled "Prevention - Routine Practices" directed staff to assist residents with hand hygiene before activities.

The PSW acknowledged they did not assist the resident using a mobility device with hand hygiene after entering the dining room for their meal. A RPN indicated that residents should be assisted with hand hygiene prior to meals.

Failure to assist residents with hand hygiene increased the risk of transmission of infection.

Sources: Observation of meal service, the home's policy titled "Prevention - Routine Practices" Index ID: IFC B-15 last revised date of June 27, 2022, interviews with a RPN and other staff.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that Screeners cleaned, sanitized and disinfected frequently touched contact surfaces in the Rapid Antigen testing area.

The licensee failed to implement measures in accordance with the IPAC Standard. Specifically, the IPAC program failed to ensure enhanced environmental cleaning procedures were completed, as required by Additional Requirements 9.1 (g) under the IPAC Standard.

Rationale and Summary

Responsibilities of the Healthcare Screener/Reception Relief staff included ensuring pens and all high touch points of the Screener's work area were cleaned, sanitized and disinfected throughout the day. This included at the beginning and end of each shift, after someone tested positive and after each test.

A Screener acknowledged that they did not clean, sanitize and disinfect after each test. They cleaned the tables and chairs at the end of their shift and if there was a positive test result in

the Rapid Antigen Test area. The RPN/IPAC Lead acknowledged that the Screener should be wiping down chairs and table after each test.

Sources: The home's job description for Healthcare Screener/Reception Relief, and interviews with a Screener and other staff.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure the provision of the care set out in the plan of care was documented for the resident's participation in recreation programming.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) that the home was not assisting and supporting the resident to participate in programs of interest.

The majority of resident's participation in programs were self-directed and included visiting family/friends and watching television. Since the resident's admission there were 13 documented times where staff attempted to engage resident but was absent, sleeping or chose not to attend.

The home's policy titled "Programs – Documentation" directed staff to include individualized needs and interests of the resident using the care plan. The Life Enrichment staff were directed to complete attendance records for residents.

A Life Enrichment Aide (LEA) acknowledged that when the resident had visitors, they tended not to interrupt them and would invite to programs when the resident was alone in the room. The Resident and Family Services Coordinator acknowledged that LEAs should still invite the resident to programs even when having visitors.

Another LEA acknowledged that they were aware that the family would like the resident to participate in programs of interest. This LEA acknowledge that they attempted to invite the resident to programs, however, these attempts were not consistently documented. The Manager of Programs and Volunteer Services acknowledged that LEAs are expected to document each time a resident is invited to programs and the reason for the absence. The Manager of Programs and Volunteer Services acknowledged they were aware that the family

wanted the resident engaged in more programs and acknowledged documentation needed improvement.

The two LEAs and the Manager of Programs and Volunteer Services were aware that the family requested resident to be invited to a specified program of interest. This was not reflected in resident's written plan of care related to programs of interest.

Sources: Resident's clinical records, the resident's activity attendance, the home's policy titled "Programs – Documentation" Index I.D.: PM H-46 last revised date of July 2022, and interviews with the LEAs and other staff.

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WRITTEN NOTIFICATION RESPONSIVE BEHAVIOURS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 58 (2) (c).

The licensee has failed to ensure that the assessment of resident's responsive behaviours were co-ordinated and implemented on an interdisciplinary basis.

Rationale and Summary

The resident had an identified health condition and was assessed to require a referral to an external resource team for follow-up.

When the home's physician had spoken with the resident and their family, there were concerns with the resident's behaviour at the time. The physician ordered a referral to an external resource team, and noted the family requested as soon as possible due to increased risk to the resident. A RPN sent the referral via electronic mail (e-mail). There was no further follow-up to the referral.

A Registered Nurse (RN) acknowledged no external consultation note was in the resident's file, and they had resent the referral to the external resource team months after the initial referral, when the family inquired about the status. The DOC acknowledged that staff did not follow-up with the referral to the external resource team appropriately. The DOC acknowledged that if external resource team was involved earlier, the resident's mood could have been better managed.

Sources: Resident's clinical records, e-mails from the RN and RPN regarding external resource team referral, home's policy, and interview with the RN and other staff.

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WRITTEN NOTIFICATION PLAN OF CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the resident's plan of care for the use of incontinent product was provided as specified in the plan.

Rationale and Summary

A complaint was received by the MLTC about the continence care of the resident. The resident was incontinent of bowel and bladder and required the use of a specified incontinent product.

On a specified date, it was noted that the resident's family requested an incontinent product to change the resident. Staff had provided a smaller sized incontinent product and noted there were no other incontinent products available.

A PSW and RPN acknowledged that a smaller size brief was provided to resident when the family requested for an extra one. A second PSW reported that the resident would often require extra incontinent products during their shift. Extra incontinent products were reported to be stored in the unit utility room. The second PSW acknowledged that, on a specified date, the resident had a smaller size incontinent product used and it was soiled when they went to assist the resident. The second PSW acknowledged that the incontinent product was too small for the resident, and it could not be closed properly.

Sources: Resident's written plan of care, resident's progress note from a specified date, and interviews with the PSWs and other staff.

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