Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 22, 2024.	
Inspection Number: 2024-1442-0001	
Inspection Type: Critical Incident	
Licensee: The Rekai Centres	
Long Term Care Home and City: Wellesley Central Place, Toronto	
Lead Inspector Trudy Rojas-Silva (000759)	**Inspector Digital Signature** Trudy Rojas-Silva Digitally signed by Trudy Rojas-Silva Date: 2024.04.08 10:29:42 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-8, 2024.

The following intake(s) were inspected:

- Intakes #00103496/ Critical Incident (CI) #2959-000017-23, #00107821/ CI #2959-000002-24 and, #00110387/ CI #2959-000005-24, related to outbreaks.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applied to the long-term care home, the operational Minister's Directive was complied with.

Rationale and Summary

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes (effective August 30, 2022), the licensee were required to ensure when a home was in COVID-19 outbreak, Infection Prevention and Control (IPAC) audits were completed weekly, as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario.

The IPAC audits for the COVID-19 outbreak between January 29 to February 17, 2024, were reviewed and it was identified that one audit was completed eight days after the last IPAC audit was done.

The IPAC lead and Director of Nursing (DON) both acknowledged the IPAC audit

was completed one day late, and should have been completed weekly as per the Minister's Directive for COVID-19 response measures for Long-term Care Homes.

Failure to complete the IPAC audit at the required interval increased the risk of ineffective outbreak management.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, COVID-19 guidance document for long-term care homes in Ontario, effective August 30, 2022, interviews with IPAC Lead and DON, IPAC audits.
[000759]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The staff failed to comply with routine practices and additional precautions in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022" (IPAC Standard).

Specifically, the staff did not properly remove and dispose of PPE as required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary

The Inspector observed a student wearing gloves while touching the door and doorknob to exit a resident's room.

This student admitted their gloves were soiled and stated the expectation was for them to remove the gloves after care and, dispose of the gloves in the garbage inside the room, instead of contaminating the door and doorknob with soiled gloves.

The home's policy on Routine Practices stated staff were to remove gloves and discard immediately after the activity for which they were used, then perform hand hygiene.

The IPAC Lead and DON both acknowledged gloves should have been removed at point of care inside the resident's room and, the action of the student did not follow routine practices in the home.

Failure to doff gloves immediately after use posed a risk of infection transmission.

Sources: Observation of the student, interview with DON, IPAC Lead, Routine Practices policy #IFC B-15, updated June 27, 2022.
[000759]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure resident symptoms of infection were recorded every shift.

Rationale and Summary

The home was on respiratory outbreak between February 29 and March 11, 2024. According to the line list there was a total of nine residents affected. Five residents did not have their symptoms recorded every shift when they exhibited symptoms of infection.

The IPAC lead acknowledged five residents symptoms were not recorded every shift. The DON advised the expectation were to record residents experiencing symptoms every shift.

There was moderate risk when the home failed to document symptoms indicating the presence of infection every shift.

Sources: Review of residents clinical records, interview with IPAC Lead and DON. [000759]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home.

Rationale and Summary

Email communication from public health declaring the home on respiratory outbreak was sent to the home on February 29, 2024, at 15:22 hours.

A critical incident (CI) was submitted to the Director on March 1, 2024, at 13:01 hours.

The IPAC lead acknowledged the Director should have been immediately informed when the home became aware of the outbreak on February 29, 2024.

The DON acknowledged that the outbreak was submitted late to the Director.

Failure to submit CI reports within the appropriate time line may have resulted in the Director being unaware of the outbreaks and taking actions as necessary.

Sources: CI #2959-000005-24, Public health email communication, interview with IPAC Lead and DON.
[000759]