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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 25, 2018	2018_462600_0006	017942-16, 013909-17	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

GORDANA KRSTEVSKA (600)

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 8, 9, and 10, 2018.

During this inspection the following complaints were inspected:
#017942-16 - regarding the plan of care, laundry service and dealing with complaints;
#013909-17 - regarding neglect.

During the course of the inspection, the inspector(s) spoke with Director of Nursing Care (DNC), Director of Resident Care (DRC), attending physician, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and resident.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

A complaint was submitted to the Ministry and Long Term Care on an identified date regarding a situation a couple years prior, when staff had trouble to perform a procedure, causing discomfort to the resident. The resident was sent to hospital for further assessment and treatment.

Review of resident #003's chart revealed the resident was admitted to the home with a medical condition. Review of the resident's written plan of care revealed that the resident had a procedure to be performed at a clinic monthly. Review of the medication administration record indicated that the staff was to monitor the resident was attending the clinic monthly.

Review of the resident's progress notes for 2014, the identified period in the complaint, revealed the resident had been going out independently for the procedure. However, for a specific month, there was no documentation about resident #003 going out for the procedure. The following month, the documentation read the registered staff had called the clinic regarding scheduling an appointment, but the clinic told the RN they could not book an appointment as the resident had not paid a fee that they promised would be pay for in the previous month. Further progress notes in the identified month indicated the home tried to correspond with the power of attorney (POA) who wanted to set up an appointment for the resident to go to a different clinic and perform the procedure however the resident did not go and the procedure was not performed. Review of the attending physician's progress notes from an identified date, indicated that the procedures had not been performed for a period of three consecutive months. When the RN #101 tried to perform the procedure, even with a use of treatment, there was some obstruction and resistance causing discomfort to the resident. The resident was sent to hospital for further assessment and have the procedure performed.

Interview with the RN #101 stated the practice in the home is the registered staff are to perform the procedure monthly and as needed. Residents with a medical condition will be referred to a clinic to have their procedure completed by a specialist. The registered staff is to monitor those residents to make sure they have the appointment scheduled timely. Further the RN stated that they recall resident #003 having a procedure and their visit to their specialist, and them calling the clinic to set up an appointment for resident #003's procedure. However the RN did not recall the dates when resident #003 had not been booked for an appointment to the clinic for the procedure.

Interview with Director of Resident Care (DRC) indicated that the staff is expected to provide care to the resident as specified in the plan of care and in this case, the DRC

confirmed that resident #003’s progress notes from the identified period indicated that the procedure of resident #003 was not performed monthly as it was specified in the resident plan of care. [s. 6. (7)]

Issued on this 28th day of May, 2018

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

Original report signed by the inspector.