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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2015	2015_157210_0009	T-894-14	Complaint

Licensee/Titulaire de permis

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

SLAVICA VUCKO (210)

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): April 13, 14, 15, 16, 17, and 20, 2015.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nurse (RN), Director of Nursing Services (DON), family members, resident's substitute decision maker (SDM). Reviewed clinical records and observed provision of care.

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

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

- **1 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designate of the resident substitute decision-

maker (SDM) has been provided the opportunity to participate fully in the development and implementation of the of the resident's plan of care.

Review of the clinical records for resident #1 indicated the resident was admitted to the home on an identified date and discharged after four days. During this period the resident was treated for responsive behaviors with an identified medication. Three days after the admission the morning dose was increased.

Review of the CCAC admission documents revealed that the resident has two family members, one living in area close to the long term care (LTC) home and another one farther away. However the family member from the longer distance from the home has legal power of attorney (POA) for personal care for which this document was a part of the admission documents. The consent for treatment was communicated and admission documents were signed with the resident's daughter who lives close to the LTC home.

Interview with the acting director of resident care indicated because both family members were listed as POAs for personal care in the computer, anything that would require consent related to personal care the registered nursing staff contacted the family member who lives closer to the LTC home, but does not have legal POA.

Interviews with both family members, DON and review of the clinical record confirmed the POA for resident #1 has not been provided the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. Record review indicated resident #2 was on an identified medication, according to physician's order from an identified date. On another identified date the physician's order was renewed for another three months. On an identified date the medication was discontinued and almost two months after the discontinuation the medication was initiated again.

Interview with a registered nursing staff indicated when there is a change in treatment or health status the POA or SDM of the resident must be notified and the notification be documented.

Interviews with an identified family member of resident #2, registered nursing staff, DON, and review of the clinical record confirmed the resident's SDM was not notified about the change in medication.

The home has created an action plan to ensure the SDM will be notified about changes in treatment and shared it with the family at a care conference held on an identified date with the interdisciplinary team.

(PLEASE NOTE: This finding of non-compliance was found during inspection # 2015_157210_0013) [s. 6. (5)]

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 the SDM has been provided the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 19th day of May, 2015

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

Original report signed by the inspector.