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
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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_0013	T-925-14	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 registered nursing staff, director of nursing services (DON), a resident's substitute decision maker (SDM) and reviewed clinical records.

PLEASE NOTE: A non-compliance was found related to the licensee's failure to ensure 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 under the Long - Term Care Homes Act.

This non-compliance [LTCHA, 2007 S.O. 2007, c.8, s. 6. (5)] was issued in Inspection # 2015_157210_0009, conducted on April 13, 2015, and is contained in the report of that inspection.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the physician order for resident #1 indicated on an identified date in 2014, the resident was prescribed a medication for an identified time period. The electronic medication administration record (eMAR) and the home's investigation record revealed the medication was discontinued on a date earlier than the identified time period and it was reinstated two days later.

Interview with resident #1's substitute decision-maker(SDM) revealed that on an identified date, the family member asked registered staff how the resident was doing and he/she was notified that the medication was discontinued because the prescription period had ended. On request of the family the medication was reinstated.

Review of the physician's prescription from an identified date revealed the original physician order for the medication was for an identified time period with additional repeats.

Review of the eMAR, interview with the resident's SDM and identified registered nursing staff confirmed that the medication was discontinued after certain time period in error. The resident was not administered the medication for two days.

The registered nursing staff confirmed resident #1 was not administered the medication in accordance with the direction for use specified by the prescriber. [s. 131. (2)]

2. Review of the physician order for resident #22 indicated the resident had an order for an identified medication every four hours when needed. Review of the eMAR and interview with DON indicated the resident was administered the medication on an identified date, less than two hours apart. On an identified date, the resident was hospitalized for two days and the hospital discharge documents indicated the resident was treated for lack of responsiveness and likely secondary to excessive administration of the same type of medication.

The home performed additional training to the registered nursing staff who administered the medication.

Review of the clinical record, home's investigation records and interview with DON confirmed that the medication was not administered in accordance with the direction for use specified by the prescriber.

PLEASE NOTE: This finding of non-compliance was found during inspection # 2015_157210_0011) [s. 131. (2)] [s. 131. (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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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.