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
Feb 20, 2015	2015_246196_0001	T-000037-14	Resident Quality Inspection

Licensee/Titulaire de permis

HELLENIC CARE FOR SENIORS (TORONTO) INC
33 WINONA DRIVE TORONTO ON M6G 3Z7

Long-Term Care Home/Foyer de soins de longue durée

HELLENIC CARE FOR SENIORS (TORONTO) INC.
215 TYRREL AVENUE TORONTO ON M6G 4A9

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

LAUREN TENHUNEN (196), BEVERLEY GELLERT (597), MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 9, 12, 13, 14, 15, 2015

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Recreation Program Coordinator, Personal Support Workers (PSW), Recreation Program staff, RAI Coordinator, Social Worker, Dietary staff, Housekeeping staff and Maintenance staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

As evidenced by:

On January 13, 2015, Inspector #106 observed resident #002 transfer from their bed into a wheelchair. A staff member assisted the resident and both small top bed rails were in the up position. On January 8, 2015, #S-100 reported that the resident uses the bed rails for transferring and bed mobility and on January 13, 2015, #S-101 reported the same.

On January 13, 2015, #S-100 reported that the home has started to complete bed rail assessments for residents and called the RAI coordinator to provide the bed rail assessments. The RAI coordinator reported that a bed rail assessment for Resident #002 had not been completed. [s. 15. (1) (a)]

2. On January 8, 2015, Resident #010 was observed lying in bed with bilateral upper side rails elevated. The most recent MDS assessment identified the use of "other type of side rails used daily" and the current care plan and kardex noted the use of bed rails. An interview was conducted with #S-100 on January 13, 2015, regarding the use of bilateral upper side rails for this resident and it was reported that Resident #010 has not had a bed rail assessment completed. [s. 15. (1) (a)]

3. On January 9, 13 and 15, 2015, Inspector #597 observed Resident #020 sleeping in their bed with bilateral 1/4 rails elevated. The current care plan for Resident #020, noted the use of bed rails to move in bed. An interview was conducted with #S-102 who stated that Resident #020 uses the small side rails for bed mobility and to assist with transfers. An interview was conducted with #S-103 on January 15, 2015 regarding bed rail assessments and they reported that a bed rail assessment had not been completed for Resident #020. [s. 15. (1) (a)]

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 that ensures that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs, were fully respected and promoted.

As evidenced by:

On January 14, 2015, Inspector #106 observed a PSW and a RPN take Resident #004 into the resident's washroom. The PSW was observed to exit the washroom leaving the resident washroom door and the door to the resident's room both open, sounds of the resident in the washroom were audible from the hall.

When the RPN exited the washroom the inspector asked the RPN if it was common practice to leave the doors open when the residents were in the washroom and they stated that it was not. [s. 3. (1) 8.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those door must be kept closed and locked when they are not being supervised by staff.

As evidenced by:

On January 9th, 2015, the following ground floor doors were unlocked and the key pads were not working; the bathing room door across from a resident room and the laundry chute door by the elevators. #S-104 confirmed to the inspector that these doors should have been locked.

In addition, the following first floor doors were unlocked and the key pads were not working; the linen closet and the soiled utility room across from the Director of Care's (DOC) office. #S-105 and #S-103 confirmed to the inspector that both of these doors should be locked. The bathing room door beside a resident's room was observed to have a white cloth stuffed into the lock to prevent the door from closing and locking and there were no staff were present. This was confirmed by #S-105 that this door should be locked and a PSW was then asked to remove the cloth and ensure the door was locked. [s. 9. (1) 2.]

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Issued on this 21st day of February, 2015

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

Original report signed by the inspector.