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

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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 4, 2015	2015_378116_0004	T-1165-14	Complaint

Licensee/Titulaire de permis

HELLENIC HOME FOR THE AGED INC.
33 WINONA DRIVE TORONTO ON M6G 3Z7

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

HELLENIC HOME - SCARBOROUGH
2411 LAWRENCE AVENUE EAST SCARBOROUGH ON M1P 4X1

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

SARAN DANIEL-DODD (116), NICOLE RANGER (189)

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): February 26, 27, March 2, 3, 4, 5, 6, 9, 10, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered dietitian, social worker, registered staff, personal support workers (PSW), residents, Power of Attorney (POA) and the substitute-decision makers (SDM) of resident #001.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #001 requires the use of an identified therapy to manage an identified medical condition. The medication administration record (MAR)for a specified period documents that the resident is to receive the identified therapy at a specified rate.

On an identified date, resident #001's Power of Attorney (POA) requested for a staff member to assess the residents response to the identified treatment. It was observed at this time that the specified treatment was not being administered as prescribed. The resident was assessed and deemed to not be in any distress.

Interviews held with registered staff members and PSWs provided conflicting information regarding the responsibility of ensuring that the prescribed treatment was available to be administered at all times. An interview with the DOC confirmed that the licensee's policy entitled "identified therapy and services" was revised after this incident to instruct staff to check the treatment cylinders at the beginning, the middle and the end of each shift. The cylinder should be refilled if below the halfway mark.

The written plan of care did not provide clear directions to staff regarding the usage of the identified therapy.[s. 6. (1) (c)]

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 plan of care sets out clear directions to staff and others who provide direct care to residents' related to identified therapies and prescribed creams, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who requires continence care products have sufficient changes to remain clean, dry and comfortable.

The written plan of care for resident #001 documents that the resident requires assistance of two persons for toileting related to decreased mobility. The residents' incontinent brief is to be checked every two hours and changed if incontinent.

Record review and staff interviews confirmed that on an identified date, resident #001's family member requested the resident to be changed and the resident was not changed until an hour and a half after the original request. The charge nurse confirmed that the PSWs did not change the resident and the PSWs were instructed that the resident is to be checked and toileted every two hours. [s. 51. (2) (g)]

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 all resident's who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 119. Retaining of pharmacy service provider

Specifically failed to comply with the following:

s. 119. (4) The written contract must provide that the pharmacy service provider shall,
(a) provide drugs to the home on a 24-hour basis, seven days a week, or arrange for their provision by another holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 119 (4).
(b) perform all the other responsibilities of the pharmacy service provider under this Regulation. O. Reg. 79/10, s. 119 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the pharmacy service provider provide drugs to the home on a 24-hour basis, seven days a week, or arrange for their provision by another holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the Drug and Pharmacies Regulation Act.

Record review for resident #001 revealed that upon return from the hospital on an identified date, the physician ordered a prescribed cream to be applied to an identified area at a specified frequency. Staff interviews confirmed that the prescribed cream was not available for two days as the pharmacy was closed. Interview with members of management of the home revealed that during the time of this incident, there was not a second pharmacy provider in place to provide drugs to the home on a 24 hour basis, seven days a week when the main pharmacy was not available. [s. 119. (4)]

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 pharmacy service provider provide drugs to the home on a 24-hour basis, seven days a week, or arrange for their provision by another holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the Drug and Pharmacies Regulation Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date, the medication cart on an identified unit was observed to be in the hallway outside of an identified dining room unlocked and unsupervised. Residents were observed to be transported through the hallway to the dining room and visitors to the unit were within close proximity to the medication cart. An interview held with the assigned registered staff member confirmed that he/she had forgotten to lock the cart and that the medication carts are to be secure and locked at all times when unsupervised. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the 24-hour admission care plan is based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement coordinator.

Resident #001 was admitted to the home on an identified date. The admission form completed prior to the resident's admission documents the resident's brief medical history and medical condition(s).

Record review of the minimum data set (MDS) 24 hour initial admission assessment and the initial plan of care revealed that an identified medical condition was not documented and there were no interventions in place for management of the identified medical condition.

An interview held with a member of management confirmed that all documentation is to be reviewed prior to creating the initial 24 hour written plan of care and all medical diagnoses are to be documented. [s. 24. (4)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: a response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Over an identified period, the POA and substitute-decision maker (SDM) for resident #001 lodged multiple written and verbal complaints to the home regarding the care of resident #001.

Record review revealed and interviews held with the Administrator and Director of Care confirmed that due to the large number of complaints received, they were not all responded to. [s. 101. (3)]

WN #7: 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.

Record review for resident #001 revealed that upon return from the hospital on an identified date, the physician ordered a prescribed cream to be applied to an identified area at a specified frequency. Staff interviews confirmed that the prescribed cream was not available for two days as the pharmacy was closed. The DOC and charge nurse confirmed that the resident did not receive the medicated cream as prescribed. [s. 131. (2)]

Issued on this 25th day of May, 2015

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

Original report signed by the inspector.