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
Jul 9, 2015	2015_251512_0008	T-1676-15	Resident Quality Inspection

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

TILDA HUI (512), JULIENNE NGONLOGA (502), SOFIA DASILVA (567)

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): April 1, 2, 7, 8, 9, 10,13, 14, 15, 16 & 17, 2015.

Additional inspections related to the following Log#s were also completed during this inspection:
1) T-887-14, complaint,
2) T-1042-14, complaint,
3) T-1159-14, complaint,
4) T-2288-15, complaint.

During the course of the inspection, the inspector(s) spoke with the Administrator, director of care (DOC), clinical care coordinator (CCC), support care coordinator (SCC), food service manager (FSM), environmental service manager, activation manager, activation staff, registered dietitian (RD), physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), housekeeping aide, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observations in home and resident areas, observations of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **3 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. 65. No interference by licensee
A licensee of a long-term care home,
(a) shall not interfere with the meetings or operation of the Residents' Council or the Family Council;
(b) shall not prevent a member of the Residents' Council or Family Council from entering the long-term care home to attend a meeting of the Council or to perform any functions as a member of the Council and shall not otherwise hinder, obstruct or interfere with such a member carrying out those functions;
(c) shall not prevent a Residents' Council assistant or a Family Council assistant from entering the long-term care home to carry out his or her duties or otherwise hinder, obstruct or interfere with such an assistant carrying out those duties; and
(d) shall ensure that no staff member, including the Administrator or other person involved in the management or operation of the home, does anything that the licensee is forbidden to do under clauses (a) to (c). 2007, c. 8, s. 65.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home staff, including management, do not interfere with the meetings and operation of the Family Council.

Observation made on an identified date and time during the inspection period revealed that the home's Family Council March 2015, meeting minutes were not posted on the family communication board in the lobby on the ground level of the home.

Interviews with Family Council representatives revealed that the home had removed the minutes of the March 2015 meeting from the family communication board. The home asked Family Council to submit documents for approval before they posted on the family communication board including the Family Council meeting minutes. Family Council was informed by the home to resubmit the minutes for approval before they posted.

Record review revealed that an email message was sent from management staff #132 on an identified date to an identified Family Council representative stating that the staff had taken the meeting minutes down because they had not been submitted for approval

to post.

Interview with the management staff #132 confirmed that the home had asked Family Council to submit documents for approval before they posted on the family communication board.

Interview with the Family Council representatives revealed that the home revised the Family Council terms of reference dated May 16, 2012, with the addition of three items which Family Council members felt were restricting conditions to the operation of the Family Council.

Review of the home's policy titled "Family Council – Hellenic Home Terms of Reference" revised February 12, 2015, revealed the following three items were added to the previous edition:

• "Quorum – The Council will maintain a formal member list, which will be accessible for review by residents and family members. Meetings' official business is to be conducted with a Quorum of 2/3 of active members being present. Minutes will reflect attendees and motions and votes by the Quorum in attendance."
• "Minutes – Minutes will be noted and kept for the perusal of family members and residents on request. Minutes should also be shared with the administrator of the home."
• "Concerns or recommendations – Concerns and recommendations may be submitted after the majority of Council has votes to do with a Quorum in attendance. The motions and results of votes are to be documented in the minutes." [s. 65.]

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 home staff, including the administrator or other person involved in the management or operation of the home, do not interfere with the operation of the Family Council, to be implemented voluntarily.

WN #2: 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 physician's order sheet for resident #013 indicated that the resident's medications were to be crushed as specified by the nurse practitioner and the physician on an identified date. Review of the progress notes for the resident revealed that on an identified date five months after, the resident was given the medication whole.

Interview with RPN staff #144 confirmed that the medication was administered whole on the later identified date and that the medication was not administered to the resident in accordance with the directions for use as specified by the prescriber. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's staff participate in the infection prevention and control program.

Observation made on an identified date and time, and at an identified unit in the home, revealed PSW staff #102 coming out of the spa room holding the door with his/her gloved hands. Upon enquiry, the PSW stated that he/she and his/her co-worker had just finished providing personal care to a resident. The PSW admitted that he/she had handled the soiled care products prior to him/her touching the door. The PSW confirmed that he/she should have removed the soiled gloves and performed hand hygiene before touching any furnishings.

Interview with the DOC confirmed that it is the expectation of the home that staff remove soiled gloves after care and perform hand hygiene before touching other furnishings. [s. 229. (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 home's staff participate in the infection prevention and control program, to be implemented voluntarily.

WN #4: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents to have his or her personal health information within the meaning of the Personal Health Protection Act, 2004 kept confidential in accordance with that Act, is fully respected and promoted.

Observations on two identified dates and times, and at two identified units, revealed medication pouches being discarded in the garbage bins on the medication carts. Further, the garbage was disposed with regular garbage.

Interviews with RPN staff #114, #124 and #143 confirmed that empty medication pouches were thrown into the garbage bin with residents' personal health information.

Interviews with the director of care (DOC) confirmed that the medication pouches should be disposed of such that resident's personal health information is not legible. Interview with the DOC confirmed that the staff are to put water in the garbage to make the print illegible. [s. 3. (1) 11. iv.]

WN #5: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident #003 was observed on two identified dates during the inspection period, sitting in his/her wheelchair tilted at 45 degree angle, and he/she was being repositioned every two hours.

Review of the home's policy titled "Definition of personal assistance services devise (PASD) Appendix IV", indicated that "a PASD is used to assist a person with an activity of daily living (ADL) that includes positioning".

Interview with allied health staff #119 indicated that the resident had been assessed and was identified as not able to shift his/her weight independently, and was at high risk for skin breakdown. The staff indicated that a category V wheelchair which was designed for residents who cannot shift their own weights independently was recommended for the resident to use as a PASD.

Interviews with RPN staff #114 and nursing management staff #122 confirmed that an order from the physician and a consent from the resident's SDM were not obtained for the use of the wheelchair as a PASD. Interview with RPN staff #114 also confirmed that the nursing staff did not know the wheelchair was used for the resident as a PASD. The nursing and allied health staff did not collaborate in assessing the resident's use of the wheelchair. [s. 6. (4) (a)] (502) [s. 6. (4) (a)]

WN #6: 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 doors must be kept closed and locked when they are not being supervised by staff.

Observations made on an identified date and time revealed the following doors leading to non-residential areas were unlocked and unsupervised:

-on the third floor, the clean utility room was unlocked and contained equipment, supplies and an oxygen tank
-on the third floor, the soiled utility room was unlocked and contained dirty linens, soiled briefs and other soiled items.

Interviews with PSW #142 confirmed that the above-mentioned rooms should have been locked while unsupervised by staff. [s. 9. (1) 2.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's furnishings are kept clean and sanitary.

Observations made on two identified dates in an identified unit's dining room revealed that seven dining room chairs were stained.

Interviews with housekeeping staff #139 and the director of facility service (DFS) indicated that when the dining room chairs are stained, nursing staff send a requisition for a deep cleaning. The housekeeping staff and DFS also indicated that it was the home's procedure for the housekeeping staff to retrieve the stained chairs and wash them using a specific chemical to remove the stain. The DFS confirmed that he/she had not received a requisition from nursing staff related to the cleaning of the above mentioned chairs. The housekeeping staff #139 confirmed that the dining room chairs were stained and indicated that he/she had not cleaned the chairs to remove the stain in the past six months which was an expectation of the home. No documentation related to the cleaning of the dining room chairs was provided. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

Observation of resident #010 on an identified date during the inspection period revealed, and interviews of PSW staff #103, #127, and #128, on day and evening shifts confirmed that the resident had his/her own teeth and did not wear dentures.

Review of the minimum data set (MDS) assessment of an identified date, indicated that the resident had dentures. A review of the MDS assessment history indicated that the resident had been wearing dentures for the past two years and 10 months. Review of the resident's written plan of care indicated that the resident wore dentures. The plan also indicated that staff were to verify that dentures were in the resident's mouth, cleanse the resident's dentures after meals, and remove and soak dentures for the resident every evening. [s. 26. (3) 12.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of plan of care for resident #005 revealed that the resident was identified as having a staged pressure ulcer on an identified part of his/her body. Review of skin and wound assessments, the Bates Jensen Weekly Wound Assessment tool in Point-Click-Care (PCC), indicated that assessments conducted during three identified periods of time were noted to be 14 days apart.

Interviews with RPN staff #112 and the clinical care coordinator who leads the skin and wound program, confirmed that the wound assessments were not conducted weekly for the resident during the three above mentioned periods. [s. 50. (2) (b) (iv)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all fluids are stored using methods which preserve taste, nutritive value, and food quality.

Observation on an identified date and time revealed that RPN staff #114 stored a container of nutritional supplement on top of a medication cart, after using it during the previous medication administration which was two hours and 40 minutes ago.

Review of the manufacturer guideline revealed that once opened, the nutritional supplement should be refrigerated.

Interview with the RPN confirmed that he/she opened the container and used the nutritional supplement during the last medication pass. The RPN also indicated that the nutritional supplement should be stored in the refrigerator but he/she forgot to do so after use. [s. 72. (3) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are appropriate furnishings in residents' dining areas, including tables at an appropriate height to meet the needs of all residents.

On an identified date during the inspection period, the inspector observed residents #018 and #019, sitting at a dining table eating their lunches. Resident #019 was being assisted in feeding by RPN staff #124, and resident #018 was eating independently. The height of the dining table was the same height as the residents' shoulders. Both residents were observed to be small in body sizes, and were observed to have raised their shoulders above the table in order to eat.

Interview with the RPN confirmed that the dining room table was not at an appropriate height to meet the dining needs of both residents. [s. 73. (1) 11.]

WN #12: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Interview with resident #011 revealed that according to the resident he/she had 15 dollars in an envelope in his/her dresser drawer that went missing some time during an identified week. Interview with RN staff #107 and PSW staff #111 confirmed that staff were informed by the resident of the missing money. However, the RN did not document the resident's complaint on the home's "Concern" form to include item (c) to (f) as required above, which is an expectation of the home for front line registered staff to do so.

Review of the resident's progress notes confirmed that the resident had complained about having lost money.

Interview with the DOC confirmed that staff did not document the type or action taken to resolve the complaint, the final resolution, every date on which any response was provided to complainant and a description of the response and any response made by the complainant. [s. 101. (2)]

WN #13: 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.

Observation on two identified dates and times, and on an identified floor, revealed the medication cart unlocked and unsupervised. During the last observation, the inspector remained by the cart for approximately five minutes before RN staff #107 returned.

On an identified date and time, the inspector observed a container of an identified medicated cream in resident #010's room.

Review of the resident's physician order sheet revealed no indication of a physician's order permitting the resident to store medication at the bedside.

Interview with RN staff #107 confirmed that the medication should have been stored in the treatment cart after administration by staff. [s. 129. (1) (a)]

Issued on this 31st day of July, 2015

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

Original report signed by the inspector.