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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 08, 2018;	2018_484646_0002 (A1)	035030-16, 028968-17, 028975-17	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

IVY LAM (646) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An amendment has been made in the last paragraph of WN #1 to correct that it was resident #002's who required the 1:1 staff.

Issued on this 8 day of March 2018 (A1)

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

Original report signed by the inspector.

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IVY LAM (646) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Janurary 25, 26, 29, and 30, 2018.

The following inspection was completed:

Critical Incident System (CIS) Inspections:

Log #028975-17 related to Prevention of Abuse and Neglect.

Complaint Inspections:

Logs #035030-16 and #028968-17 related to Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Manager of Programs and Support Services and Social Services Worker, Registered Practical Nurse (RPN), PSWs, 1:1 agency PSWs, Substitute Decision-Makers (SDM) and Residents.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This inspection was initiated related to complaint #028968-17 and CIS #028975-17, submitted on identified dates, related to alleged abuse toward resident #001 by resident #002 while both residents were in an identified home area.

Review of resident #002's written plan of care and behavioural monitoring at the time of the incident revealed that resident #002 had numerous identified responsive behaviours. Interventions for the resident's behaviours, which included:
- 1:1 staff close monitoring;
- Monitor hourly for safety and intervene as necessary to ensure safety;

Review of resident #002's Dementia Observation System (DOS) Behavioural Management system revealed that resident #002's specific responsive behaviours were identified.

Review of the home's video recordings of the incident on an identified date at an identified period of time, revealed:

At an identified time, resident #001 was observed to be seated at an identified home area, with an empty seat beside the resident. One minute later, PSW #106 was observed to speak with resident #002's 1:1 staff (PSW #101) in the identified home area, and both PSW #106 and resident #002's 1:1 staff brought another resident in wheelchair to the spa room.

Six minutes after both PSWs went to the spa room, the video recording revealed that resident #002 walked out of their room down the hallway towards the identified home area, and reached the identified home area on their own. Resident #002's 1:1 staff was not with the resident at the time.

Nine minutes after both PSWs went to the spa room, resident #002’s 1:1 staff was observed to come out of the spa room to walk towards the identified home area, and return to the spa room at one minute later, speaking through the door of the spa room, then goes down the hallway opposite to the identified home area where resident #001 and #002 were seated. PSW #106 was still in the spa room at the time and had not come out to the common area.

Within the minute when PSW #106 walked away, resident #001 was observed to get up from their seat and attempt to move to the center seat. The camera was not able to capture the third seat where resident #002 sat, but observed an identified part of a resident on the footage, which the Manager of Programs and Support Services and Social Services Worker confirmed was resident #002's identified part of the body. Resident #002's identified part of the body was seen to make a shoving motion with resident #001’s identified part of the body as resident #001 sat down.

PSW #106 was observed to come out of the spa room with another resident, and walked to the identified home area, standing in front of resident #001, and observed to be speaking with residents #001 and #002. No other contact was observed, and resident #002 was not observed for the remainder of the video recording. Another PSW came to redirect resident #001 away. Review of resident #001's progress notes revealed that resident #001 was assessed by registered staff and physician for pain and injury, and assessments have revealed neither signs of pain nor injury.

Interview with PSW #106 revealed that on the evening of the incident, the PSW had detected that another resident had a bowel movement, and had asked the 1:1 of resident #002 for assistance, as resident #002 was in their own room at the time. PSW #106 further revealed that they are now aware the PSWs are not to ask the 1:1 for help as the 1:1s are to be monitoring their own resident, but the unit was short-staffed that day, and this was why the PSW had asked the 1:1 for assistance. The PSW further revealed that they were not aware resident #002 had left their room, and the next time PSW #106 saw resident #002, they were already in the identified home area of the incident.

Interview with 1:1 staff for resident #002 (PSW #101) revealed PSW #106 had asked for assistance with a resident to the spa room, and resident #002 was in their room at the time. The 1:1 staff further revealed that they had informed PSW #106 that they were going on break, but had not asked the nurse at the time as the

nurse was in the nursing station.

Interview with RPN #104 revealed that that evening, the 1:1 had not notified them when they were going on break, and at the time of the incident, RPN #104 and the other PSW (PSW #118) were also on break. The RPN revealed that the 1:1 staff are there for their residents only, and staff should not be asking the 1:1 for help, as there would be no one covering to monitor resident #002 and it would not be safe. RPN #104 further revealed that PSW #106 should have waited for PSW #118 to return from break before providing care to other residents.

Interview with the administrator, DOC and the ADOC revealed that the care plan for resident #002 was for the 1:1 staff to closely monitor the resident, to minimize risk and to intervene and prevent altercations from happening. They further revealed that on the day of the incident, resident #002's 1:1 was not present with the resident during the time the 1:1 provided assistance to another resident in the spa room, and during the incident where resident #002 had an identified physical altercation with resident #001 in the identified home area. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 8 day of March 2018 (A1)

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

Original report signed by the inspector.