Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 4, 2020	2020_780699_0006	023708-19	Critical Incident System

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

PRAVEENA SITTAMPALAM (699), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 4-7, 10-12, 2020.

The following Critical Incident System (CIS) report intake was inspected:

-Log #023708-19 related to the fall of a resident.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC); Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), physicians, dietary aides, social worker, office manager, residents, substitute decision makers (SDM), and family members.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, staff training
records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy and procedure the home had, instituted or otherwise put in place was complied with.

In accordance with O. Reg 79/10, s. 48(1) 1 and in reference to O. Reg 79/10 s. 49(1), the licensee is required to have, a fall prevention and management program policy and procedure. Confirmation was made that policies and procedures for fall prevention and management program were in place, however, they were not complied with.

The home's Falls Management policy states to "initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed and the resident is on anticoagulant therapy". Furthermore, on February 11, 2020, the ADOC posted the following message on the Point Click Care Facility Bulletin Board to all registered staff: HIR will be initiated for all unwitnessed falls and witnessed falls with suspect of injury, especially head injury. It should be documented in the progress notes that HIR has been initiated. HIR should be completed for 48 hours, and according to the DOC, start with every 15 minutes x 4 times, then hourly x 4 times, then every shift until 48 hours are completed.

a. Record review of the critical incident report and the home's electronic PCC documentation indicated that resident #020 experienced an unwitnessed fall and was later transferred to hospital for further assessment. The resident was diagnosed with a specific injury; and was transferred back to the long-term care home the next day.

A review of resident #020's Head Injury Routine (HIR) Neurological Assessment indicated that the resident was appropriately assessed prior to leaving for hospital, however when the resident returned to the home, HIR assessments were not continued

during the evening and night shifts for up to 48 hours post fall.

During separate interviews, RPN #121 and ADOC #102 both verified that resident #020's HIR was not completed as indicated in the home's policy and the information posted by the ADOC.

b. Record review of the CIS report and the home's PCC documentation indicated that resident #022 experienced an unwitnessed fall and was found by a PSW. The resident was assessed by the registered staff, denied experiencing pain and was found to have no visible injury.

A review of resident #020's HIR Neurological Assessment indicated that the resident was not appropriately assessed during the first few hours of the neurological assessment. The registered staff assessed the resident and documented at 1850 hours, 1930 hours, 2000 hours and 2100 hours, instead of every 15 minutes x 4 times; then hourly x 4 times.

During separate interviews, RPN #121 and ADOC #102 both verified that resident #022's HIR was not completed as indicated in the policy.

c. Record review of the CIS report and the home's electronic PCC documentation indicated that resident #023 experienced an unwitnessed fall and was found by a PSW. The resident was assessed by the registered staff, denied experiencing pain and was found to have no visible bruising or injury at the time of the fall.

Record review indicated that resident #023 was prescribed and administered an anticoagulant.

A review of resident #023's chart indicated that the resident did not have a HIR neurological assessment completed related to the unwitnessed fall although they were prescribed and administered anticoagulant medication.

During an interview, ADOC #102 verified that resident #023's HIR should have been completed as indicated in the policy.

Therefore, the home failed to ensure registered staff complied with the Falls Management policy for residents #020, #022, and #023. [s. 8. (1) (a),s. 8. (1) (b)]

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, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #2: 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:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #020's plan of care was based on an interdisciplinary assessment of safety risks.

The Ministry of Long-term Care (MLTC) received a CIS report related to resident #020's fall incident.

Record review of the critical incident system (CIS) report and the home's electronic Point Click Care (PCC) documentation indicated that resident #020 experienced an unwitnessed fall and was later transferred to hospital for further assessment. The resident was diagnosed with a specific injury. Record review and multiple staff interviews verified that the resident had a habit of sitting on their mobility device. Therefore, staff suspected that the resident may have attempted to sit on their mobility device and it moved backward, or the resident may have stood up from a seated position when the fall occurred. Record review of the resident's plan of care indicated that the resident's habit of sitting on their mobility device was not included in the plan of care as a safety risk.

During separate interviews, RN #117, RPN #112 and ADOC #102 verified that they have observed the resident sitting on their mobility device; identified that there was a safety risk to the resident and acknowledged that the information should have been included in the resident's plan of care related to falls risk and safety.

During the interview, the ADOC stated the expectation was for the registered staff to include this information in the resident plan of care so that staff consistently discourage the resident from sitting on their mobility device and encourage them to sit safely in order to promote safety and prevent further risk of falls. The ADOC further acknowledged that the information was not included in the plan of care. [s. 26. (3) 19.]

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 resident's plan of care must be based on, at a minimum, interdisciplinary assessment of their safety risks, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #020 was assessed using a clinically appropriate pain assessment instrument when the resident's pain was not relieved by initial interventions.

The MLTC received a CIS report related to resident #020's fall incident.

Record review of the CIS report and the home's electronic PCC documentation indicated that resident #020 experienced an unwitnessed fall, and was later transferred to hospital for further assessment. The resident was diagnosed with a specific injury; and was transferred back to the long-term care home.

A review of the medication administration record (MAR) indicated that the resident was assessed immediately after the fall, complained of a specific level of pain and was administered pain medication at that time. Record review of the progress notes also indicated that later on, the resident complained of increased level of pain; however, the registered staff did not complete and document a pain assessment using the home's specifically designed pain assessment instrument. The resident was transferred to hospital for further assessment and treatment and was diagnosed with an injury. The resident returned to the long-term care facility, was prescribed a new analgesic to control their pain, however there was no pain assessment documented.

During separate interviews, RPN #121 and #112, ADOC #102 and DOC #101 verified that the home currently has a specifically designed pain assessment instrument, however the document was only used to assess resident's pain quarterly, and not with change in condition or readmission from the hospital.

Therefore, the home failed to ensure resident #020 was assessed using a clinically appropriate pain assessment instrument when the resident's pain was not relieved by initial interventions. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 6th day of March, 2020

[redacted]

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

Original report signed by the inspector.