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_0004	001699-20	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

PRAVEENA SITTAMPALAM (699)

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 4-7, 10-12, 2020.

Off site interviews were conducted on the following date(s): February 13, 2020.

The following complaint intake was inspected:

-log #001699-20 related to concerns of neglect, skin integrity, power of attorney (POA) notification of care, and abuse investigation related to skin tears.

During the course of the inspection, the inspector(s) spoke with the Administrator, 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:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated and were consistent with and complemented each other.

The Director received a complaint regarding the improper care of resident #001.

Record review of resident #001's progress notes indicated that on a specific date, resident #001 was weighed. The resident experienced a significant change in weight compared to the previous month. There was no documentation that the physician was informed or a referral to the RD was made related to this increase in weight. Further review of the progress notes indicated that the resident started exhibiting a symptom, at which point, a referral to the physician was made, however there was no documentation to indicate that the physician was informed of the weight change at that time.

Record review of RD #109's progress notes indicated that the resident was on the weight exception report and that resident #001 had a weight change in one month, which can partly be associated with an identified symptom. Further review of the progress note indicated that weight trend should be monitored, however no frequency was indicated. The RD again stated in a progress note to monitor resident #001’s weight trends and refer to RD as needed a month later.

Record review of resident #001's progress notes indicated that the resident was noted to have an identified symptom and a note was left in the physician binder. Another note indicated that the resident experienced another weight change.

In an interview with RD #109, they indicated that when they received the weight report, they asked staff to re-weigh the resident three times because of the change in resident #001's weight. They further indicated that they would follow up with the physician if there was identified symptoms.

Further review of the progress notes did not indicate that the physician was notified of the weight change by either registered staff or registered dietitian.

Review of the progress notes, orders, and care plan did not indicate that there was an interdisciplinary discussion regarding resident’s weight trend, how it should be monitored and at what frequency.

In an interview with RN #117, they indicated for residents who have a specific condition, certain symptoms and vital signs would be monitored. They further indicated that if the resident's weight had a sudden change, the physician would be notified immediately, and typically, a specific frequency of weights would be ordered.

In an interview with RPN #124 and #125, they stated that they could not recall whether or not the physician was informed of the resident's change in weight in the identified months. They stated that the physician should have been informed of the weight change and referral made to the RD.

In an interview with physician #122, they indicated that they should be informed of any sudden weight change of a resident. They could not recall whether they were informed that resident #001 had a change in weight.

The inspector was unable to review the MD binder notes as they were shredded as per

the DOC.

In an interview with ADOC #102, they indicated that a resident with an identified diagnosis would have certain symptoms and vital signs monitored. If a resident suddenly changes in weight, the physician would be immediately notified or have a nurse practitioner (NP) come assess the resident. They acknowledged that staff should have reported to the physician immediately regarding the change in resident #001's weight.

The licensee failed to collaborate with each other in the assessment of resident #001's weight change. A referral to the RD or the physician was not made when the resident experienced a significant weight change. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

The Director received a complaint related to the power of attorney (POA) not being notified regarding the care of resident #001.

Review of resident #001’s clinical profile on PointClickCare (PCC), it indicated that FM #200 was the POA for care, and listed FM #201 and #202 as next of kin. Review of the POA form indicated that the POA was changed to FM #200 on a specified date. The home received this form from FM #200 on a later date.

Review of the progress notes indicated that on three separate occasions, FM #201 was contacted instead of FM #200:

In an interview with ADOC #102, they indicated the POA should be contacted first and if they cannot be reached, then the next of kin can be contacted. [s. 6. (5)]

3. The licensee has failed to ensure that when resident #001 was reassessed and the plan of care related was being revised because care set out in the plan of care had not been effective, different approaches were not considered in the revision of the plan of care.

The Director received a complaint regarding resident #001 having many areas of altered skin integrity.

Record review of resident #001's care plan with full revision history indicated two interventions for altered skin integrity.

Further review of the care plan indicated three different interventions for preventative skin care.

Record review of resident #001's progress notes and weekly skin assessments showed that the resident continued to develop different skin alterations to various areas of their body from a specific period of time. Review of the skin assessments indicated that source of the alterations were related to a skin condition.

Review of both physiotherapy and dietary's progress notes from July 2019 to January 2020 did not indicate any further additional recommendations related to resident #001's altered skin integrity.

In an interview with RPN #125, they could not recall what was in the plan of care related to resident #001's skin integrity. They indicated that the resident had a skin condition. They further indicated that transferring might have caused the resident's skin alterations. The above mentioned care plan did not indicate that the resident had a specific skin condition.

In an interview with ADOC #102, they indicated that the plan of care would be reassessed with different approaches if it was not effective, however that is often done quarterly. They further indicated that staff were very gentle with resident #001 to prevent skin alterations.

In an interview with DOC #101, they indicated that they would expect staff to assess the resident if they continued to exhibit altered skin integrity, such as checking if the sling during transfer needs to be changed. They indicated that resident #001's plan of care was reassessed.

The licensee has failed to ensure that when resident #001's plan of care related to altered skin integrity was ineffective, different approaches were considered in the reassessment of the plan of care. The resident continued to exhibit altered skin integrity with the above-mentioned interventions in place. [s. 6. (11) (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 that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was not neglected by staff.

Neglect as outlined in Section 5 of the Regulation (O.Reg.79/10) means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Record review of resident #001's progress notes indicated that the resident was noted to have an identified symptom and a note was left in the physician binder.

Review of the physician's note dated indicated that a diagnostic test was ordered due to a previous identified condition after an assessment of the resident's symptom.

Review of the physician orders showed that diagnostic test was ordered and signed off by two nurses. Review of progress notes from a from an identified period of days did not indicate that a diagnostic test was completed.

Another note indicated that the resident experienced a change in weight.

In an interview with RD #109, they indicated that when they received the weight report, they asked staff to re-weigh the resident three times because of the change of resident #001's weight. They further indicated that they would follow up with the physician if there was identified symptoms.

Further review of the progress notes did not indicate that the physician was notified of the above-mentioned weight change by either registered staff or registered dietitian.

The inspector was unable to review the MD binder notes as they were shredded as per the DOC.

Review of the progress notes indicated that the diagnostic test was completed seven days after it was ordered. Further review of the progress note indicated that the physician was verbally informed the diagnostic test was completed and that the physician told staff to send the resident to hospital if the diagnostic test showed that resident had an identified diagnosis. Resident #001 was now observed to have increased symptoms. Resident #001 was subsequently sent to hospital for treatment.

Review of the diagnostic test results from the hospital report indicated that resident #001 had the identified diagnosis. The resident subsequently received treatment.

In interviews with ADOC #102, and RPN #126, they indicated the typical turnaround time for having diagnostic tests completed in the home is two to three days. If there is a delay in the diagnostic test, the registered staff would follow up and inform the incoming shift to follow up as well. Review of the progress notes did not indicate that on-coming shifts were notified of the diagnostic test not being completed.

In an interview with ADOC #102, they indicated that a resident with an identified diagnosis would have certain symptoms and vital signs monitored. If a resident suddenly changes in weight, the physician would be immediately notified or have a nurse practitioner (NP) come assess the resident. ADOC #102 indicated that staff could have been more vigilant in reporting to the physician regarding resident #001’s symptoms and that the resident was partly provided the care they required.

In an interview with DOC #101, they acknowledged that the diagnostic test should have happened sooner and that the physician should have been notified sooner of the

resident's weight change.

The licensee has failed to ensure that resident #001 was not neglected by staff. The resident was observed to have an identified symptom resulting in the physician ordering a follow up diagnostic test to be completed to rule out a previous identified diagnosis. The registered staff did not follow up on the diagnostic test for a period of seven days while the resident continued to exhibit symptoms. Through staff interviews, it was identified that the typical turnaround time for diagnostic tests to be completed in the home was approximately two to three days. The diagnostic test for resident #001 was completed seven days later, the same day the resident was transferred to hospital for further assessment and treatment. [s. 19. (1)]

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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper care/treatment of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

The Director received a complaint about the investigation the home conducted into an altered skin integrity that occurred which resulted in the resident being admitted to the hospital.

Record review of resident #001's progress notes indicated that the resident sustained a skin injury. The resident was sent to the hospital to be assessed.

Review of the home's investigation notes indicated that PSW #129 and PSW #130 were interviewed regarding the care that was provided to the resident on that shift. Further review of the investigation package indicated that as a result of the investigation, the two PSWs were given disciplinary action.

In an interview with DOC #101, they indicated that an investigation was initiated to determine the cause of the skin injury. Through their investigation, they could not determine how the skin injury happened, however, PSW #129 and #130 were given disciplinary action.

In an interview with Administrator #100, they indicated that during the course of the investigation, they suspected that something may have occurred causing the skin injury and that PSW #129 and #130 were not being forthcoming with what occurred with resident #001. Based on this, the home decided to give disciplinary action to the identified staff. The Administrator acknowledged that this should have been reported to the Director. [s. 24. (1)]

Issued on this 6th day of March, 2020

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

Original report signed by the inspector.