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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 21, 2021	2021_769646_0009	007740-20, 007934-20, 008919-20, 010143-20, 010240-20, 012633-20	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

IVY LAM (646), IANA MOLOGUINA (763)

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): May 6, 7, 10-14, 17-21, and 26, 2021.

The following intakes were completed in this complaint inspection:
Log #007740-20 related to nutrition care;
Log #007934-20 related to infection prevention and control, nutrition care, and personal support services;
Log #008919-20 related to nutrition care and falls prevention;
Log #010143-20 related to allegations of abuse, admission and discharge, falls prevention, medication management, and pain management;
Log #010240-20 related to falls prevention; and
Log #012633-20 related to infection prevention and control and hospitalization.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Infection Prevention and Control Lead (IPAC) lead, Falls lead, Registered Dietitian (RD), Dietary Aides (DA), Personal Support Workers (PSW), Physiotherapist (PT), Social Worker (SW), Housekeeper, 1:1 sitter, 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:
Admission and Discharge
Critical Incident Response
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

5 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	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in a resident's nutritional care collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A resident was to receive a specific diet texture. Registered Dietitian (RD) assessments showed the resident continued to tolerate and was recommended to continue their diet.

The resident was provided a different diet texture than what was recommended.

Two PSWs and one Dietary Aide (DA) stated the ate better with the texture they were given rather than the recommended texture, and the resident had not been given the recommended texture for a period of time. The PSWs indicated the RPN was aware but did not know if the nurse had referred the RD.

The RPN stated the resident should be provided the texture per care plan. The RPN indicated there were no concerns with the resident's eating that required an RD referral. The RPN did not recall if the PSWs had told them the resident had difficulty tolerating their recommended texture.

The RD indicated they have never observed the resident's eating, and assessments were based on intake records. They stated they would observe residents if staff had identified concerns, but no referrals had been made for food tolerance issues for this

resident.

There was a risk to the resident when there was a lack of collaboration for timely assessment and to ensure a safe and tolerable diet was consistently provided to the resident.

[Sources: Resident's current nutrition care plan, dietary binder, Home's policy (Personal Support Worker (PSW) - Position Description, issued September 2019; Registered Practical Nurse (RPN) - Position Description, issued September 2019); Registered Dietitian's (RD) Quarterly Nutrition Assessment – January and April 2021; observations of the resident at mealtimes; interviews with PSWs, Dietary Aide (DA), RPN, RD, Director of Care (DOC), and other staff.] [s. 6. (4) (a)]

2. The licensee has failed to ensure that the staff and others involved in the falls prevention care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A resident had a history of falls, and their Substitute Decision Maker (SDM) had requested an intervention to prevent the resident's falls.

An interdisciplinary team meeting was held after the fall, and the Physiotherapist (PT) and Assistant Director of Care (ADOC) documented the plan to allow the intervention. The Resident Assessment Instrument (RAI) Coordinator documented this was communicated with the SDM.

A PSW and RPN stated that resident's family continued to request the intervention, but this was not in the resident's written care plan. The PSW indicated staff would provide the intervention only when family members were present. The RPN stated staff would not provide the intervention as it was not included in the resident's care plan.

The PT indicated they had not updated the resident's care plan as they had expected the RAI coordinator or registered staff to do so and communicate the intervention to direct care staff.

The DOC later communicated with the SDM that their suggested intervention was not

safe for the resident and would not be put into place. This discussion was not documented in the resident's medical record or communicated to staff. The DOC stated their final documentation should have been put into the medical record to allow better collaboration and communication with the staff and this was not done.

[Sources: Resident's current falls care plan, progress notes, DOC's own records for the resident, risk management notes, physiotherapist's assessments, post fall huddle assessments; observations of the resident, staff to resident interactions; and interviews with PSWs, RPN, PT, DOC, and other staff.] [s. 6. (4) (a)]

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 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 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 a specific monitoring protocol required under the home's falls policy was completed for a resident.

O. Reg 79/10, s. 48 (1) required the licensee to ensure a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home’s policy "Fall Management" that indicated the required monitoring was to be completed after an unwitnessed fall or when a specific injury was suspected.

The resident was at risk of falls and experienced occasional falls, including two unwitnessed falls which required the above monitoring. Staff started monitoring for the first fall but stopped completing the tool after the second fall occurred and did not restart the monitoring protocol for the second fall on that day. Staff confirmed monitoring should have been completed.

Sources: resident clinical records (care plan, progress notes, assessments, risk management assessments), "Fall Management" policy), staff interviews (RPN, RPN, DOC). [s. 8. (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 the plan, policy, protocol, procedure, strategy or system, is in compliance with and is implemented in accordance with applicable requirements under the Act; and is complied with, to be implemented voluntarily.

WN #3: 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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure food and fluids were served using methods which prevented contamination and food borne-illness.

A resident was served a meal in their room with entree covered, utensils and beverages uncovered. The resident did not begin eating as they were sleeping. Approximately 45 minutes later a housekeeping staff began cleaning in the room including the table with the resident's meal on it. The resident remained in bed and requested staff to leave their meal on the side table. Staff assisted the resident to set up their meal approximately one hour after service.

The housekeeping staff acknowledged they should not have cleaned the side table while the resident's meal was on the table.

There was risk of contamination and food-borne illness when the housekeeping staff cleaned the table with the meal on it, and the meal remained on the side table for one hour prior to consumption.

The DOC stated the housekeeper should not have cleaned the table which has food on it, as it was not safe to do so from an infection prevention and control perspective, and that staff should be aware how long food should be left out for the resident to ensure the food is kept safe for the resident.

[Sources: Resident’s care plan; mealtime observations of the resident; interviews with PSW, RPN, housekeeper and the DOC.] [s. 72. (3) (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 all food and fluids in the food production system are served using methods to prevent contamination and food borne illness, to be implemented voluntarily.

WN #4: 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 staff participated in the implementation of the infection prevention and control program.

A) Observation of a resident's room showed a droplet and contact precaution sign requiring the wearing of mask, eye protection, and gown when coming into close contact with the resident.

Observation of a staff member seated beside the resident at mealtime showed the staff member was not wearing a gown. Follow-up observation the same day showed the same staff wore the gown backwards, with the tie at the front of their body. The staff member was aware they needed to wear a gown when in close contact with the resident and preferred to tie it in the front for comfort.

The home's Infection Prevention and Control (IPAC) lead stated when staff are in close contact with a resident under the droplet and contact infection precaution, they were expected to wear a gown. They further indicated that gowns are to be tied at the back, and that all staff had received education on how properly don and doff Personal Protective Equipment (PPE), including the gowns.

They stated the identified member had not followed the home's PPE donning practice when they did not wear a gown, or wore it improperly, when in close contact with the resident.

B) The home's Personal Protective Equipment policy indicated a procedure mask with ear loops was to be worn by staff at all times. Face shield or goggles were to be used when staff were within two meters of a resident.

A PSW was observed with their eye protection on the top of their head while delivering meals to residents' rooms.

The home's IPAC lead stated that the staff were expected to wear eye protection when within two meters of residents. The staff needed to interact with residents when delivering the meals and were expected to keep their eye protection in place during meal delivery, and this was not done.

[Source: Home's Personal Protective Equipment policy; Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007; Observation of staff to resident interactions for the resident, mealtime observations of staff and resident interactions, interviews with the identified staff, IPAC lead and other staff.] [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 all staff participate in the implementation of the Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident that caused injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

The resident had an unwitnessed fall that resulted in a transfer to hospital with injuries. The PT assessed the resident and indicated that their transfer status and need for an assistive device changed after their readmission.

Record review indicated that there was no Critical Incident System (CIS) report submitted to the Director for this incident. Staff interviews confirmed that the resident sustained injury after this fall that resulted in a significant change in their health condition and that a report should have been submitted for this incident.

Sources: resident clinical records (care plan, progress notes, assessments, risk management assessments, hospital discharge records), staff interviews (RPN, RPN, DOC). [s. 107. (3)]

Issued on this 22nd day of June, 2021

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

Original report signed by the inspector.