Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Amended Public Report (A1)

Report Issue Date: March 03, 2023	
Inspection Number: 2023-1425-0002	
Inspection Type: Critical Incident System	
Licensee: Hellenic Home for the Aged Inc.	
Long Term Care Home and City: Hellenic Home - Scarborough, Scarborough	
Lead Inspector Ramesh Purushothaman (741150)	**Inspector Digital Signature** Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2023.03.03 16:08:19 -05'00'
Additional Inspector(s) Jack Shi (760) was also present during this inspection	

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report findings summary has been revised for NC #003 on page 4 of the report to reflect the following:

The home reported the complaint to the Ministry, twelve days after they received it.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 21 - 24, 2023

The following intake(s) were inspected:

- Intake: #00015286 - [Critical Incident (CI): 2941-000012-22] Improper care relating to medication administration.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Safe and Secure Home
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b**)**

The licensee has failed to ensure that the infection prevention and control (IPAC) standard for long-term care home issued, April 2022, by the Director was implemented in accordance with the standard:

- 10.1 The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary
Observations revealed multiple Isagel Alcohol-Based Hand Rub (ABHR) bottles with 60% alcohol content, in use on all the floors of the home. Personal Support Worker (PSW), Registered Practical Nurse (RPN), Registered Nurse (RN), confirmed that they used the product to perform Hand Hygiene (HH), both for the staff and the residents.

Director of Care (DOC) informed that all of the Isagel ABHR had been removed and were replaced with Purell Hand Sanitizer bottles with 70% alcohol content.

There is a risk to the residents if the ABHR with less than 70% alcohol content was used, as its effectiveness in prevention of spread of infectious diseases may be decreased.

Sources: Observations, Review of "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), Interview with PSW, RPN, RN and DOC.

Date Remedy Implemented: February 22, 2023

(741150)

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that a policy directive that applied to the Long-Term Care Home (LTCH), the Minister's Directive: COVID-19 response measures for LTCHs, was complied with.

In accordance with the Directive, licensees were required to ensure that ABHR products used were not expired as set out in the document, "Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes".

Rationale and Summary
An expired Hand Sanitizer (HS) product was found on a cart used by a staff. The staff confirmed that they did not realize the HS product was expired and removed it from the cart.

Director of Care (DOC) also confirmed that the expired ABHR was removed from the floor.

There is a risk of decreased effectiveness in prevention of spread of infectious diseases if an expired ABHR product was used.

Sources: Observation, Review of "Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes" document, Interview with Activity Staff, and DOC.

Date Remedy Implemented: February 23, 2023

(741150)

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The Licensee has failed to ensure that they immediately forward to the Director any written complaint that it receives concerning the care of a resident.

Rationale and Summary
The home had received an email from a resident's Substitute Decision Maker (SDM) about concerns relating to medication administration as ordered by the doctor.

The home reported the complaint to the Ministry, twelve days after they received it.

DOC stated that they wanted to gather more information before the complaint was reported to the Ministry. They also said that they did not think that this was a care related concern and hence they did not report it to the director immediately.

Failure of the home to notify the Director immediately about resident's care related concern, had minimal impact to the resident.

Sources: CIS report 2941-000012-22, review of the complainant's email, interview with DOC.

[741150]