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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 23, 2023	
Inspection Number: 2023-1425-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Hellenic Home for the Aged Inc.	
Long Term Care Home and City: Hellenic Home - Scarborough, Scarborough	
Lead Inspector Britney Bartley (732787)	**Inspector Digital Signature** Britney Bartley Digitally signed by Britney Bartley Date: 2023.08.23 13:30:12 -04'00'
Additional Inspector(s) Nrupal Patel (000755)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 10, 11, 14- 16, 2023

The following intake(s) were inspected:
- Intake: #00090753 – related to falls prevention and management.
- Intake: #00092568 - Complaint related to a resident's fall.

The following intake was completed in this inspection: Intake: #00084789, were related to falls prevention management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director related to a resident fall and was transferred to the hospital with an injury.

A review of the resident's clinical records indicated the resident's plan of care requires staff to apply a safety device as a fall's prevention strategy. Personal Support Worker (PSW) #100 reported they did not apply the safety device as per the care plan, right before the fall.

The Director of Care (DOC) and Quality Improvement and Education Manager acknowledged that the resident did not have safety device in place at the time of the fall.

By the home failing to apply the safety device puts the resident at risk for falls as the interventions in place would assist in the resident's fall prevention.

Sources: A resident's clinical records, interview with PSW #100, Quality Improvement and Education Manager and the DOC.

[000755]

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The licensee has failed to ensure that a door was maintained in a good state of repair.

Rationale and Summary

A complaint was submitted to the Director, related to concerns around a resident's fall.

The resident had an unwitnessed fall and sustained an injury. A review of the resident's clinical records indicted the resident reported to Registered Practical Nurse (RPN) #106 that the door in their room contributed to their fall.

After the resident's fall, a video footage was taken of the door and revealed that the door required repairs.

Interviews with RPN #106, Personal Support Worker (PSW) #107 and lead maintenance #105 indicated there are procedures in place for routine, preventive, and remedial maintenance. However, prior to the fall, they were not aware that the door needed repair.

By the door being in a state of repair, the resident was placed at risk and as a result they fell.

Sources: A resident's clinical records, maintenance work order form, video footage of the door, interviews with PSW #106, RPN #106 and lead maintenance #105.

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