Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 19, 20, 30, 31, Feb 1, 3, 2012	2012_031194_0006	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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Eight Residents, the Administrator, Director of Care, Support Care Coordinator, RAI Coordinator,two Registered Nurses, four Registered Practical nurses, eight Personal Support Worker,and complainant

During the course of the inspection, the inspector(s) reviewed clinical health records, Incontinence policies,observed resident care, Observed dining service for two days,

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. An Identified resident's(#2)Treatment Administration Record (TAR) for January 2012 indicates that, a dressing was to be applied every 5 days and as needed. The TAR indicates that the dressing was to be completed on Jan 06, 11, 16, 21, 26 & 31, 2012.

There is evidence in the Clinical Health Record indicating that the dressing was applied on January 16, 2012. The TAR was signed for by the nurse on January 16, 2012.

On January 17 & 18, 2012 identified resident (#2) was observed by the Inspector. No dressing was evident.

Review of the progress notes for January 17 & 18, 2012 was completed, no documentation in regards to resident refusal, change in orders or assessments in noted related to the application of the dressing.

Review of the plan of care for Resident(#2)does not give clear direction to staff for changing the dressing on an "as needed" basis.

The written plan of care for Resident (#2)does not provide clear direction to staff and others who provide care to the resident in relation to when the dressing would be changed on an "as needed" basis [s.6.(1)(c)]
2. Review of the Clinical Health Record for an identified resident(#3) indicates that a physician order was not obtained for the administration of an identified drug for the resident.

The plan of care for the resident(#3) does not identify the use of the identified drug for the resident.

Resident's(#3)progress notes document that on December 30, January 3,4,9,10,11, and 16th the resident received the identified drug.
The resident was observed by inspector receiving the identified drug on January 18 and 19, 2012.

The plan of care set out for resident (#3) does not give clear direction to staff and others who provide direct care to the resident [s.6(1)(c)]
3. Review of the Clinical Health Record for an identified resident(#3) indicates that a physician order was not obtained for the administration of an identified drug for the resident.

Review of plan of care for resident(#3) does not indicate the use of an identified drug.

The progress notes document that during December 2011 and January 2012 resident (#3) received the identified drug.

Resident (#3) was observed by the Inspector to be receiving the identified drug on January 18 and 19, 2012.

The written plan of care for the identified resident (#3) did not set out the planned care for the resident in regards to the use of identified drug.[s.6.(1)(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 that ensures that the written plan of care for each residents sets out the planned care for the resident and clear direction to staff and others who provide direct care to the resident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. An identified resident(#4) returned from hospital in January, 2012 with a prescription. During inspection the inspector noted the prescription attached to return paper work from hospital, in the doctor's book.

Review of the resident(#4) clinical health record was completed. A progress note was made indicating that the resident returned from hospital with prescription that needed to be confirmed by the physician. The progress notes reviewed for the relevant period, do not reflect any documentation that the physician had reviewed the prescription or ordered the medication.

The physician communication book for the specified week in January, 2012 does not reflect any information from the nursing staff about reviewing an order received from the hospital for the identified resident(#4).

The Medication Administration Record for January 2012,for identified resident was reviewed. The identified prescription received from the hospital had not been ordered or transcribed.

Registered Practical Nurse Jugraj, was interviewed by the inspector and was unable to explain, why the prescription script received from the hospital was not processed.

The identified prescription had not been processed for the resident, at the time of the inspection. (#4).

The licensee did not ensure that drugs were administered to the resident in accordance with the direction for use specified by the prescriber[r.131(2)]

2. The licensee received an order for an identified resident(#3) from physician to hold a medication for 10 days and then resume order.

The Medication Administration Record was reviewed and it is noted that the medication continued to be held 2 days after the medication should have been resumed.

The inspector verified that the medication was available at the home for the identified dates, when it should have been resumed.

The licensee did not ensure that drugs were administered to resident (#3) in accordance with the direction for use specified by the prescriber[r.131.(2)]

3. Review of the Clinical Health Record for an identified resident(#3) indicates that a physician order was not obtained for the administration of an identified drug for the resident.

Resident(#3) clinical health records, including RAI MDS assessment, progress notes and Medication Administration Records identifies the resident as using the identified drug.

Resident (#3) was observed by inspector receiving the identified drug on January 18 and 19, 2012.

The licensee administered to resident (#3) a drug that had not been prescribed for the resident.[r.131(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 all drugs that are used or administered at the home have been prescribed for the resident and are administered to the resident in accordance with the direction for use specified by the prescriber., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. At 11:10 hours the Inspector was sitting at the nursing station when the indicator panel rang to identify that a resident (#1) was using the call bell. Inspector noted that at 11:15 hours the indicator panel stopped ringing. At 11:20 hours the Inspector went to observe and speak to resident(#1) regarding call bell. Resident(#1) was observed sitting in a wheelchair, facing the wall, with the resident's back to the bathroom door. The identified resident was waiting for staff to assist with toileting. The Inspector asked the resident if staff had come in and turned off the call bell, resident(#1) stated "yes, and the staff said they would be back". The Inspector returned to resident's room at 11:30 hours to observe resident still sitting in the wheelchair, waiting for staff to return. At 11:33 hours Inspector went to locate staff. The Inspector spoke to Registered Practical Nurse Jugraj, and explained the situation. The nurse then went to find staff. Nurse Jugraj returned at 11:35 hours to inform Inspector that the identified resident was a 2 staff assist for transfer and that staff would assist the identified resident as soon as possible. Staff arrived to assist identified resident at 11:45 hour to assist with toileting.

The resident's right to be treated with courtesy, respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was not promoted in the home.[s.3(1)]

Issued on this 27th day of February, 2012

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

Chantal Lafreniere (194)