Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 3, 2013	2013_196157_0011	002379,002416,002273,000055	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

PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)

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): March 18, 19, 20, 21, 2013

During the course of the inspection the following complaint logs were inspected: 002379-12, 002273-12, 002416-12, 002399-12, 000012-13, 000028-13, 000045-13, 000055-13, 000152-13, 000194-13

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Assistant Director of Care(ADOC), Registered Social Worker/Activation Manager, Registered Dietitian(RD), Food Service Manager(FSM), RAI Coordinator,7 Registered Practical Nurses (RPN's),1 Registered Nurse (RN), 1 Dietary Aide, 7 Personal Support Workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents, observed care and services provided to residents, reviewed facility policies and procedures related to responsive behaviours, blood glucose monitoring, resident observation records, care and use of mechanical lifts and slings, fall prevention and management, admission procedures, complaint management and continence care and management, reviewed Resident Council minutes, Family Council promotional materials, complaint and concern log, observed staff interactions with residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Nutrition and Hydration

Personal Support Services

Reporting and Complaints

Residents' Council

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The plan of care for resident #03 fails to provide clear directions to staff and others who provide care to the resident:
Three hours after resident #03 was admitted to the home the resident was injured, transferred to hospital for assessment and was diagnosed with a fractured hip.
Information received by the home prior to the resident's admission identifies the following:
- Resident was previously admitted to hospital with a fractured hip sustained as a result of a fall
- Pre admission MDS assessment identifies that the resident is at risk for falls due to unsteady gait and the resident's risk of falls is triggered for care planning
There is no evidence that falls prevention interventions were put in place when the resident was admitted to the home. [s. 6. (1) (c)]

2. The plan of care for resident #0014 does not set out clear direction to staff for the identified strategies to manage the resident's responsive behaviours.
The Administrator and nursing staff have confirmed that resident #0014 is provided 1:1 care when needed for behaviours. Nursing staff identified a number of interventions in place to manage the resident's behaviours. The plan of care does not provide direction for these identified strategies. [s. 6. (1) (c)]

3. The plan of care for resident #02 fails to provide clear directions to staff and others who provide care to the resident:
- The clinical health record, as confirmed by staff, identifies specific circumstances that will trigger the resident's responsive behaviours. The plan of care fails to identify these triggers and provide direction for managing the resident's behaviours in these circumstances.
- The ADOC confirmed that the resident was approved for a 1:1 care provider. The resident's plan of care does not provide clear direction for constant 1:1 care provision.
- The clinical health record for the resident, as confirmed by staff, indicates that the resident frequently refuses care. The plan of care fails to provide clear direction to staff for interventions to manage the resident's care related to care refusals.
- The plan of care for the resident provides inaccurate direction for dining procedures.
- The plan of care for the resident fails to provide clear, specific information related to the resident's behaviours.
- The resident's plan of care fails to provide direction related to the prevention, identification and treatment of an identified infection
- The plan of care fails to provide direction related to actions to be taken to manage

situations when the resident refuses/resists behavioural interventions.[s. 6. (1) (c)]

4. The care set out in the plan of care for resident #0014 was not provided as specified in the plan related to responsive behaviour.

Plan of care for resident #0014 directs staff for a toileting routine for the resident, to be documented in the BSO binder.

The documentation in the BSO binder and progress notes, and as confirmed by staff on the unit, does not support that the resident is being toileted according to the plan of care. [s. 6. (7)]

5. Care set out in the plan of care was not provided to resident #02 as specified in the plan:
- 1:1 staffing for resident #02 is funded by the High Intensity Needs Program and has been in place 24 hours a day 7 days a week. A review the clinical health record for the resident, frequently indicates that the 1:1 care provider is not present with the resident at all times. The resident was observed on two separate occasions, with no 1:1 care provider present. The DOC has confirmed that this was a practice that was resolved with redirection of staff.
- The plan of care for resident #02 provides direction related to the resident's dietary requirements. The plan of care was not provided as specified in the plan on March 20 and 21, 2013 when observation of meal service for resident #02 identified that food and beverages were not offered in accordance with direction in the plan of care.
- Physician's orders for resident #02 provide direction for monitoring requirements of the resident's health condition. The resident's clinical health record indicates that care was not provided as directed by the plan of care when the physician's orders were not followed on 13 identified dates/times in February 2013. [s. 6. (7)]

6. The care set out in the plans of care for resident's #0015, #0016, #0017 were not provided as specified related to monitoring of the residents' health conditions:
Resident #0015 - The resident's clinical health record indicates that care was not provided as directed by the plan of care when the physician's orders were not followed on 4 identified dates/times from March 1 - 19, 2013.
Resident #0016 - The resident's clinical health record indicates that care was not provided as directed by the plan of care when the physician's orders were not followed on 8 identified dates/times from March 1 - 19, 2013.

Resident #0017 - The resident's clinical health record indicates that care was not provided as directed by the plan of care when the physician's orders were not followed on 5 identified dates/times from March 1 - 19, 2013. [s. 6. (7)]

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 written plans of care provide clear direction to staff and others who provide direct care to residents related to falls prevention, responsive behaviours and management of infections;
to ensure that care set out in the plan of care is provided as specified in the plan related to continence care, nutritional care interventions, 1:1 care and monitoring of health status, 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:

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. The licensee failed to comply with O. Reg. 79/10 s.131(2) when medications was not administered to residents in accordance with the directions for use specified by the prescriber.

Resident #0015 - Review of MAR and physician's order for the month of March 2013 indicates that the resident did not receive medication in accordance with the directions specified by the prescriber on 10 identified dates/times. [s. 131. (2)]

Resident #0016 - Review of MAR and physician's order for the month of March 2013 indicates that the resident did not receive medication in accordance with the directions specified by the prescriber on 9 identified dates/times. [s. 131. (2)]

Resident #0017 - Review of MAR and physician's order for the month of March 2013 indicates that the resident did not receive medication in accordance with the directions specified by the prescriber on 10 identified dates/times. [s. 131. (2)]

Resident #002 - Review of MAR and physician's order for the month of February 2013 indicates that the resident did not receive medication in accordance with the directions specified by the prescriber on 11 identified dates/times. (Log #000194-13) [s. 131. (2)]

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 receive medication in accordance with the directions 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The Administrator received a letter expressing a number of complaints about the care of an identified resident. The Administrator confirmed that this complaint was not immediately forwarded to the Director.(Log #0000289-13) [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Fall incident report and the home's post fall investigation identify that resident #04 was not toileted in accordance with the direction provided in the resident's plan of care. The resident suffered a fall with subsequent pain requiring an xray to evaluate the injury. [s. 36.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The home's Falls Prevention and Management Program, Nursing Administration Manual, June 2003, revised April 2012 does not provide strategies to reduce or mitigate falls to monitor newly admitted residents who have been identified as being at risk for falls. [s. 49. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee's Complaints Log identified 6 written complaints were received in 2012. The Office Manager and the Administrator confirmed that the complaints were not reviewed or analyzed quarterly. [s. 101. (3)]

Issued on this 4th day of April, 2013

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

Pat Powers #157. Chantal Lafreniere #194