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

Division de la responsabilisation et de la performance du système de santé
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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
Jan 27, 2014	2014_049143_0002	T-OOO202-14	Critical Incident System

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 20th-21st, 2014.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, residents and a Detective with the Toronto Police Services.

During the course of the inspection, the inspector(s) observed resident care and services on the Third Floor, observed storage areas for medical/nursing equipment, observed staff and resident interaction, reviewed two resident health care records, reviewed policies and procedures related to infection control, use of gloves, medication administration, acute change of condition, swallowing deficits; staffing schedules, visitor logs and staff police check forms.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
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 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. Ontario Regulation 79/10 section 114.(2). states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the homes medication administration record-treatment administration record (policy 2.24) procedure 7 states the following:
When a drug is administered the nurse must initial the box on the MAR/TAR which corresponds to the appropriate date and time of administration.

On a specified date and time resident #1 was observed to be absent of any vital signs. A review of Resident #1's medication administration record indicated that Registered Staff documented on thirteen occasions that the resident had received medications and treatments post death.

The Licensee has failed to ensure that Ontario Regulation 79/10 section 8. (1)(b) is complied with by not ensuring that the medication management system policies and procedures were complied with. [s. 8. (1)]

Issued on this 27th day of January, 2014

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

Paul Miller