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
Jul 25, 2014	2014_237500_0012	T-304-14	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

NITAL SHETH (500), VERON ASH (535)

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): June 25, 26, 27, 30, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), registered dietitian (RD), clinical care coordinator (CCC), registered staff, personal support worker(PSW), and family member.

During the course of the inspection, the inspector(s) reviewed resident's and home records and observed the use of clinical equipment ans resident's care.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

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 licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

A review of resident #012's plan of care revealed that the resident was on a specialized feeding program.

A review of the intake report revealed that the total required amount of this specialized feeding program was not delivered on eight identified days between April to June 2014.

Interview with the registered nursing staff confirmed that they have to delay the feeding program before and after resident's care and therefore the total required amount of the feeding program was not provided for the above mentioned days as ordered.

Interview with DOC and RD confirmed that nursing staff needs to prolong the provision of nourishment to ensure all is provided in a day based on the order. However, there are no clear indication to the registered staff for this practice. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
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Interview with DOC and RD confirmed that nursing staff needs to prolong the provision of nourishment to ensure all is provided in a day based on the order. However, there are no clear indication to the registered staff for this practice. [s. 6. (7)]

3. Record review revealed that resident #011's plan of care instructed staff to communicate to family new concerns noted every shift. On an identified day, the resident had fever, requiring the use of medication and cold compresses, however staff and family interviews confirmed that the family was not notified of the resident's change in status. [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 there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect.

Record review revealed that the home's current policy entitled abuse and neglect of a resident - actual or suspected dated March 2012, does not include measures and strategies to prevent abuse and neglect of residents.

Interview with the DOC confirmed that the abuse and neglect policy had not been evaluated or updated in 2013, to identify the required measures and strategies to prevent abuse and neglect of residents. [s. 96. (c)]

2. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirement for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

Record review revealed that the home's current policy entitled abuse and neglect of a resident - actual or suspected dated March 2012, listed 'reviewing the resident's rights brochure at the next departmental staff meeting' as the only staff training or retraining intervention for all staff. An interview with the home's director of care confirmed that the abuse and neglect policy had not been evaluated or updated in 2013, to include the required training. [s. 96. (e)]

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 the written policy to promote zero tolerance of abuse and neglect of residents identifies measures and strategies to prevent abuse and neglect and identifies the training and retraining requirement for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #3: 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. The licensee failed to ensure that the personal care and grooming procedure outlined in the current written resident care policy dated May 2012, is complied with.

Family and staff interviews confirmed that the personal care provided to resident # 011 did not incorporate the 'hush no rush' strategy as outlined in the home's policy. The staff were preceived to be in a hurry when providing care to the resident and staff confirmed that they have to support many residents during their shift and were unable to spend the too much time to incorporate the above strategy while providing personal care to all residents during the shift. [s. 8. (1) (a),s. 8. (1) (b)]

2. Record review and staff interview confirmed that resident #011's POA arrived at the home every morning and often stayed until late afternoon/evening in order to provide or support the provision of personal care to the resident as outlined in the plan of care. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A review of the intake reports for resident #012 revealed that registered nursing staff did not document the amount of water received by the resident during the day shift on an identified day and for 24 hours the water amounts were not documented on five identified days.

Interview with the registered nursing staff confirmed that he/she documents the intake not based on the resident's actual intake but on the ideal intake. [s. 30. (2)]

2. A review of a printed email found in the resident's chart, send by DOC to the nursing staff on January 2, 2014 at 1:24, p.m., indicates that the intake report-communication book must be completed accurately each shift. Failure to document is a medication error and staff will receive notice of medication error which will be added to their employment record and included in an annual evaluation. [s. 30. (2)]

3. Record review revealed that on an identified day, two identified PSWs did not document resident #011 provision of care, reassessment and interventions during the shift. The resident experienced a significant change in status and passed away during the shift. [s. 30. (2)]

4. Record review revealed that resident # 011's intake report sheet on an identified day was not completed by the registered staff on an identified day and the 24 hour total intake was not completed for the three identified shifts. [s. 30. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

s. 76. (6) Every licensee of a long-term care home shall ensure that the following are done:
1. The further training needed by the persons mentioned in subsection (1) is assessed regularly in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations. 2007, c. 8, s. 76. (6).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who have received training under subsection (2) received retraining in prevention of abuse, neglect and retaliation annually.

Record review and an interview with the DOC confirmed that only 27% of all staff completed the prevention of abuse, neglect and retaliation retraining in 2013. [s. 76. (4)]

2. The licensee failed to ensure that further training needs are identified and addressed at least annually.

Record review and staff interviews confirmed that the registered staff last received training related to an identified device on January 23, 2008. An interview with the clinical care coordinator confirmed that she has not provided further training for staff related to the use of the device, and that staff are trained in real time by outgoing staff using a train the trainer method at the beginning of the incoming registered staff shift. This training was provided to staff informally therefore the inspector was unable to observe and confirm with staff training records. [s. 76. (6) 1.]

3. Record review, family and staff interview revealed that the staff were challenged with the use of the equipment and the processes required for providing safe, competent care to the resident. Staff interviews confirmed that registered staff who had not previously worked with the device and agency staff are given a brief orientation to the device by the out-going registered staff. [s. 76. (6) 1.]

Issued on this 25th day of July, 2014

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

Nital Sheth