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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2018	2018_759502_0015	006919-17	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

JULIENNE NGONLOGA (502)

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): September 21, 24, 25 and 26, 2018.

The following intake was inspected: log #006919-17, related to unsafe transferring techniques.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nursing Administrator Coordinator, resident and substitute decision maker (SDM).

During the course of this inspection, the inspector observed the provision of care, staff and resident interaction, review residents' health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 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. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date the Ministry of Health and Long Term Care (MOHLTC) received a

complaint related to improper transfer. The complainant stated that while transferring resident #001 from wheelchair to bed, a PSW removed the brakes from the wheelchair, resulting in a fall. The complainant alleged that the PSW did nothing to prevent the fall as result the resident required treatment.

The inspector reviewed the progress notes from the home's electronic documentation system and confirmed that the fall incident mentioned above occurred.

The inspector met with the resident in their room during this inspection. The resident recalled the fall incident and gave the same statement that the staff unlocked their wheelchair breaks three times during the transfer. The resident said, they put their hands on the bed and tried to get up. They felt like they needed to sit, so they sat down on the edge of the wheelchair as the wheelchair had moved backwards. They told the PSW that they were falling, they started sliding and then quickly slid down to the floor onto their bottom on the right side.

The resident also said that they requested help, but the PSW did nothing to help them when they were falling. When the resident fell, they were cold and staff did nothing. This was consistent with the resident's previous statement made three days after the fall mentioned above occurred.

The inspector interviewed staff #106 during this inspection. Staff #106 indicated that they locked the wheelchair's brake on the left side and told the resident to lock the wheelchair's brake on the right side. Then resident #001 tried to reach out to the bed side rail and was not able to. The resident sat back half way in the wheelchair, started wiggling back, accidentally unlocked the brakes on the wheelchair, and the resident told them that they were going to fall. The staff indicated that they tried to pull the resident back by holding their pants, but that didn't work. Slowly the wheelchair was moving back and the resident was going down. The staff said they placed their hands on the resident's head while the resident was sliding down.

The inspector interviewed staff #100 during this inspection. Staff #100 indicated that they attended to the resident after the fall. Resident #001 was in pain, upset and blaming the PSW that they did not know how to transfer them. The staff also indicated that they did not remember if the wheelchair's brakes were locked.

The inspector met with the Administrator, who acknowledged that staff #106 did not follow safe transferring techniques. They indicated that the staff was provided re-

education on safe transfer techniques. [s. 36.]

2. As a result of non-compliance with O.Reg 79/10, r. 36 found for resident #001 related to unsafe transfer, the resident sample was expanded to include resident #002.

Observation made in resident #002's room during this inspection identified a sign posted above the resident's head of the bed that described the method of transfer of the resident.

The inspector reviewed resident #002's written plan of care and noted the resident's cognitive status and that they required extensive assistance of two staff for transfer based on their medical condition.

During the course of this inspection, the inspector observed staff #105 assisting resident #002 with transfer without assistance from another staff.

Staff #105 told the inspector that the resident required one person extensive assistance instead of two persons for transfer, and that they were working short staff. [s. 36.]

3. As a result of non-compliance with O.Reg 79/10, r. 36 found for resident #001 related to unsafe transfer, the resident sample was expanded to include resident #003.

During the course of this inspection, the inspector observed staff #101 assisting resident #003 with transfer without assistance from another staff.

The inspector reviewed resident #003's written plan of care and noted the resident's cognitive status and that they required extensive assistance of two staff for transfer based on their medical condition.

Observation made in resident #003's room during this inspection identified a sign posted above the resident's head of the bed that described the level of assistance and the method of transfer for the resident.

Staff #101 told the inspector that the resident required one person extensive assistance instead of two persons for all transfers, and that they were working short staff. The staff also stated that the resident's transfer need had not changed since admission.

In a joint interview, ADOC and Administrator acknowledged that staff #101 and #105 did

not use safe transferring techniques when they assisted residents #002 and #003 without the assistance of a second PSW. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.

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The resident also said that they requested help, but the PSW did nothing to help them when they were falling. When the resident fell, they were cold and staff did nothing. This was consistent with the resident's previous statement made three days after the fall mentioned above occurred.

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2. As a result of non-compliance with O.Reg 79/10, r. 36 found for resident #001 related to unsafe transfer, the resident sample was expanded to include resident #002.

Observation made in resident #002's room during this inspection identified a sign posted above the resident's head of the bed that described the method of transfer of the resident.

The inspector reviewed resident #002's written plan of care and noted the resident's cognitive status and that they required extensive assistance of two staff for transfer based on their medical condition.

During the course of this inspection, the inspector observed staff #105 assisting resident #002 with transfer without assistance from another staff.

Staff #105 told the inspector that the resident required one person extensive assistance instead of two persons for transfer, and that they were working short staff. [s. 36.]

3. As a result of non-compliance with O.Reg 79/10, r. 36 found for resident #001 related to unsafe transfer, the resident sample was expanded to include resident #003.

During the course of this inspection, the inspector observed staff #101 assisting resident #003 with transfer without assistance from another staff.

The inspector reviewed resident #003's written plan of care and noted the resident's cognitive status and that they required extensive assistance of two staff for transfer based on their medical condition.

Observation made in resident #003's room during this inspection identified a sign posted above the resident's head of the bed that described the level of assistance and the method of transfer for the resident.

Staff #101 told the inspector that the resident required one person extensive assistance instead of two persons for all transfers, and that they were working short staff. The staff also stated that the resident's transfer need had not changed since admission.

In a joint interview, ADOC and Administrator acknowledged that staff #101 and #105 did

not use safe transferring techniques when they assisted residents #002 and #003 without the assistance of a second PSW. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.