Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 4, 2020	2020_780699_0005	000769-20, 000880-20, 001589-20, 002191-20	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

PRAVEENA SITTAMPALAM (699), ADAM DICKEY (643), 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): February 4-7, 10-12, 2020.

The following complaint intakes were inspected:

-log 000769-20 related to dining, plan of care, and responsive behaviours;
-log 000880-20 related to improper feeding and hospitalization;
-log 001589-20 related to neglect; and
-log 002191-20 related to resident's death in the home.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC); Registered Nurses, (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers, (PSW), physicians, dietary aides, social worker, office manager, residents, substitute decision makers (SDM), and family members.

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and the provision of care, reviewed resident health records, staff training
records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 has failed to ensure that the care set out in the plan of care was provided

to residents #011 and #012 as set out in the plan.

Complaints were received by the Ministry of Long-Term Care (MLTC) regarding the nutrition and hydration care for residents #010, #011 and #012.

a. Review of resident #011's order summary report showed an active order for a nutritional supplement for an identified frequency per administration. Review of resident #011's Medication Administration Record (MAR) showed entries of "9" - see nursing notes 11 times between a specified time period for administration of the nutritional supplement. Review of resident #011's progress notes showed corresponding entries to the above 11 scheduled administration times, all of which indicated either not available, or no stock.

In interviews, RPNs #103 and #111 indicated that supplementation of the nutritional supplement would be administered by registered staff at scheduled administration times and documented in the resident's MAR. The RPNs indicated that when the unit was out of stock of and it was not available to them, they were unable to administer the supplement to residents on the unit. RPNs #103 and #111 indicated that they would enter not available or out of stock in the progress notes documenting the reason for not administrating the supplement. RPNs #103 and #111 indicated they were not aware of any substitution for the nutritional supplement.

In interviews, RD #109 and Clinical Care Coordinators (CCC) #110 and #121 indicated that they were aware of the identified resident home area running out of the nutritional supplement in a specific month. RD #109 indicated that they had received an email from CCC #110 who was inquiring whether it was appropriate to substitute an alternative nutritional supplement in place of the nutritional supplement until the Food Service department could get delivery. RD #109 indicated that it was acceptable to substitute an alternative nutritional supplement temporarily. Both CCC #110 and #121 indicated that they had communicated the substitution to the charge nurse to communicate to unit staff.

b. Review of resident #012's order summary report showed an active order for a nutritional supplement for an identified frequency per administration per administration. Review of resident #012's Medication Administration Record (MAR) showed entries of "9" - see nursing notes 10 times between a specified time period for administration of the nutritional supplement. Review of resident #011's progress notes showed corresponding entries to the above 10 scheduled administration times, all of which indicated either not available, or no stock.

In an interview, the DOC indicated that they were aware of the identified resident home area running out of the nutritional supplement in a specific month and that a substitution of an alternative nutritional supplement was to be in place. The DOC acknowledged that as residents #011 and #012 had orders in place for supplementation and were not administered the supplement in the above instances the residents were not provided care as set out in the plan of care. [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 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death of resident #021.

The MLTC received a complaint related to an incident involving resident #021.

Record review of the Point Click Care (PCC) Progress notes indicated that resident #021 experienced an acute event which resulted in the resident’s death.

Record review of the PCC progress notes documented by the primary care physician was as follows:
‘Resident's condition since I started looking after them was overall stable’.

During separate interviews, RN #117, RPN #120 and PSW #118 acknowledged that the resident’s condition was stable prior to the incident, and that they did not expect the resident's death. PSW #118 informed the inspector that they provided care for resident #021 in the home for a specified period of time.

During an interview, the home’s physician stated that they did not believe the resident’s death was unexpected since they have had medical issues in the past. The physician also stated that the home did not have a definition for what constitutes an 'unexpected death' which meant it was not clearly defined.

During an interview, the home’s DOC stated that the resident’s death was not reported to the Director because the physician did not document that it was unexpected. The DOC also stated that the paramedics who responded to the call indicated that the resident’s death was not unexpected; nor was the resident’s death a coroner’s case.

In summary, the physician documented that resident #021’s health condition was 'overall stable' over a period of months. The resident did not have a documented diagnosis related to their identified cause of death diagnoses. The RN, RPN and PSW all stated during separate interviews that they did not expect the resident’s death.

Therefore, the home failed to ensure the Director was immediately informed of the unexpected or sudden death of resident #021. [s. 107. (1)]

Issued on this 6th day of March, 2020

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

Original report signed by the inspector.