Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: December 21, 2023
Inspection Number: 2023-1425-0005
Inspection Type: Critical Incident Follow up
Licensee: Hellenic Home for the Aged Inc.
Long Term Care Home and City: Hellenic Home - Scarborough, Scarborough

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2024.01.04 15:50:36 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 13, 14, 18, 2023

The following intake(s) were inspected:

- Intake: #00098499 - Critical Incident System (CIS) #2941-000025-23 - related to fall prevention and management
- Intake: #00098808 - Follow-up (FU) - related to medication management
- Intake: #00101910 - CIS (#2941-000029-23) - related to Disease Outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1425-0004 related to O. Reg. 246/22, s. 140 (1) inspected by Nicole Ranger (189)

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: FALL PREVENTION AND MANAGEMENT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the rik of injury.

The licensee has failed to comply with their Falls Prevention and Management policy related to post fall management.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and was complied with.

Specifically, staff did not comply with the home's policy for head injury routine, that upon discovering a resident had an unwitnessed fall, registered staff should complete a thorough assessment of the resident including a head injury routine (HIR).

Rationale and Summary

Resident #004 was found on the floor in their room. The resident complained of pain and a HIR tool was started.

Review of the HIR identified that an assessment was not completed at a number of intervals as required. Registered Nurse (RN) #103 confirmed that the head injury routine was not completed as per policy.

The Quality Improvement and Education Manager acknowledged that staff did not follow the home's policy of completing the head injury routine as per schedule.

Failure to assess resident #004 after the fall in accordance with the home's policy, placed the resident at risk for further injury.

Sources: CIS #2941-000025-23, home's investigation notes, policy titled "Falls Management". revised April 2023, resident #004's progress notes; interviews with RN #103, Quality Improvement and Education Manager, and other staff.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2)

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored.

IPAC Standard for Long-Term Care Homes (revised September 2023), s. 3.1 (b) states the licensee shall ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections.

Rationale and Summary
The home was in an outbreak during an identified time period. The home required staff to monitor symptoms indicating the presence of infection every shift on the unit for the affected residents.

The public health line listing identified the onset of first symptoms for resident # 001, #002 and #003 was on identified dates. All residents were placed on additional precautions accordingly.

Record review of the residents' progress notes showed that symptoms indicating the presence of infection were not documented every shift.

Quality Improvement and Education Manager and IPAC Lead #102 both indicated that symptoms indicating the presence of infections should have been monitored every shift and documented in residents' progress notes. IPAC Lead #102 acknowledged that there were missing monitoring documentation for identified residents.

There was a moderate risk when the home did not document symptoms indicating the presence of infections every shift.

Sources: Review of resident #001, #002, #003's progress notes, review of the public health line listing; interview with IPAC Lead #102 and the Quality Improvement and Education Manager.

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WRITTEN NOTIFICATION: REPORTING OF CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

s. 115 (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 (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed about

an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary
The home went into an outbreak as declared by the Public Health Unit (PHU) on an identified date. The Critical Incident Report (CIS) indicated the outbreak was declared on October 8, 2023, however the report was first submitted to the Ministry of Long-Term Care on October 10, 2023.

The Administrator acknowledged that the outbreak was declared on October 8, 2023, and was not immediately reported to the Ministry of Long-Term Care.

There was low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: Critical Incident Report #2941-000028-23, interview with Administrator, Quality Improvement Manager and Infection Prevention and Control (IPAC) Lead # 102.

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