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: April 10, 2024	
Inspection Number: 2024-1425-0001	
Inspection Type: Critical Incident	
Licensee: Hellenic Home for the Aged Inc.	
Long Term Care Home and City: Hellenic Home - Scarborough, Scarborough	
Lead Inspector Jack Shi (760)	**Inspector Digital Signature** Jia J Shi Digitally signed by Jia J Shi Date: 2024.04.11 13:09:40 -04'00'
Additional Inspector(s) Inspector Audra Sayn-Wittgenstein (000853) had attended this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3, 4, 5, 8, 9, 2024

The following intakes were inspected:
- Intake: # 00106770 - Critical Incident System (CIS) 2941-000003-24 – Related to an outbreak
- Intake: # 00109849 - 2941-000006-24 – Related to a change in a resident's health condition

The following intake was completed:
- Intake: # 00111577 - 2941-000007-24 – Related to an outbreak

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

Food, Nutrition and Hydration
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that a Personal Support Worker (PSW) collaborated with the Registered Nurse (RN) as it pertained to a resident's meal intake.

Rationale and Summary:
A resident was found by staff to have a change in their condition. The staff assessed and determined that the resident had a health condition and required further interventions. A review of the home's investigation notes indicated that a PSW had not communicated to the RN that the resident had poor intake on the day of the incident. The RN stated that if they were told that the resident did not eat well that day, they would have taken a different approach to ensure the resident's health condition was addressed. The Director of Care (DOC) stated that they would expect the PSW to have communicated the resident's intake to the RN in this situation.

Failure to ensure that the PSW collaborated with the RN related to a resident's intake may have resulted in the resident having a change in their health condition.

Sources: Interview with a PSW, an RN and the DOC; Investigation notes related to this incident; a resident's progress notes, medication administration records and Point of Care documentation. [760]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that an Registered Practical Nurse (RPN) was named in a CIS report submitted to the Director.

Rationale and Summary:
A CIS report was submitted related to a resident's change in their health condition. Upon further review, it was determined that an RPN had initially intervened when they discovered a change in the resident's condition. The RN confirmed that the RPN was involved in assessing the resident initially before the RN and the nurse manager took over the incident. The RPN was not listed in the CIS report submitted

to the Director as it related to this incident. The DOC confirmed that they should have included the RPN's name in the CIS report.

Failure to ensure that all staff members involved in an incident were listed in an incident report submitted to the Director may result in the inability of the Director to take the appropriate course of action.

Sources: CIS report # 2941-000006-24; Review of a resident's progress notes; Review of the home's investigation notes; Interview with an RN and the DOC. [760]