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
Jan 3, 2014	2013_128138_0052	O-001071-13	Complaint

Licensee/Titulaire de permis

GIBSON HOLDINGS (ONTARIO) LTD
343 Amherst Drive, Amherstview, ON, K7N-1X3

Long-Term Care Home/Foyer de soins de longue durée

HELEN HENDERSON NURSING HOME
343 Amherst Drive, Amherstview, ON, K7N-1X3

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

PAULA MACDONALD (138)

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): December 17 and December 19, 2013

During the course of the inspection, the inspector(s) spoke with several residents, the President of the Residents' Council, personal support worker students, personal support workers, a maintenance staff member, activation aides, a laundry staff member, the Assistant Director of Care, the Director of Care, a registered nurse, the Dietary Supervisor, and the Office Manager.

During the course of the inspection, the inspector(s) observed a meal service, reviewed several resident health care records, toured the home's laundry room, toured several resident rooms, and reviewed the home's maintenance logs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 73. (2)(b) in that residents who require assistance with eating or drinking were served a meal before someone was available to provide assistance.

Long Term Care Homes (LTCH) Inspector #138 observed the lunch meal service on December 17, 2013. It was observed by LTCH Inspector that the hot entrée portion of the meal was delivered to a resident at 12:20pm. The entrée was left on the table covered with a dome lid. The entrée remained at the table untouched until staff was able to assist the resident at 12:35pm, 15 minutes after the entrée was delivered. The resident only ate a bite of the entrée and refused the rest. The resident's health care record was reviewed and it stated that the resident required complete assistance with meals.

LTCH Inspector also observed that a hot entrée was delivered to another resident at 12:25pm. This too was covered with a dome lid and left on the table in front of the resident until 12:45pm, 20 minutes after it was delivered, when staff began to assist the resident with the meal. The resident only ate a few bites of the meal and refused the remainder. The resident's health care record was reviewed and it stated that the resident required total assistance with meals.

LTCH Inspector spoke with a staff member feeding one of the residents mentioned above. She stated to the LTCH Inspector that meals were delivered to the two residents, that staff were not ready to assist these two residents so the meal was placed at the table covered with a dome lid until staff members were ready to assist. [s. 73. (2) (b)]

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 residents who require assistance with eating or drinking are not served a meal before someone is available to provide assistance, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) 4. in that the licensee failed to ensure that every resident has the right to be properly sheltered, fed, clothed and groomed for in a manner consistent with his or her needs.

Long Term Care Homes (LTCH) Inspector #138 observed a lunch meal service on December 17, 2013. It was observed by the LTCH Inspector that there were at least two residents not eating their meal. One of these residents sat with his/her lunch meal and fluids in front of him/her from 12:15pm to 12:36pm and only ate a few bites of the meal and no fluids. The resident was provided verbal encouragement to eat only once. The resident's care plan was reviewed and it stated that the resident requires encouragement to eat all that is provided and to provide cereal if the resident does not eat. LTCH Inspector observed that the resident did not eat, was provided only minimal encouragement with meals, no encouragement with fluids, and was not provided cereal. LTCH Inspector observed another resident who was not eating. A meal was placed in front of the resident at 12:15pm in which s/he only took a few small bites initially. No encouragement was provided to the resident to continue to eat and the meal was removed at 12:37pm by staff. Discussion was held with the Director of Care who stated that the resident had recently been moved to that dining room so that s/he could receive more cuing and encouragement with meals. [s. 3. (1) 4.]

Issued on this 3rd day of January, 2014

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