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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2015	2015_236622_0006	033593-15	Resident Quality Inspection

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

HEATH HEFFERNAN (622), BAIYE OROCK (624), DENISE BROWN (626), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 7 - 11 and the 14 - 18, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator/ Environmental Services/Office Manager, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Dietary Supervisor, the Activity Director, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Laundry Aide, Housekeeping Aide, Maintenance, the Physiotherapist, the Dietitian, Family members, and residents.

The inspectors conducted a tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, interviewed staff, residents and family, observed and reviewed infection control practices, and restraint practices, reviewed resident and family council minutes, applicable home policies, the home's staffing schedules for the nursing department, water temperatures and hot water boilers annual service documentation.

During the course of the Resident Quality Inspection, the following complaint intakes, log# 033742-15 and 020861-15 were inspected.

During the course of the inspection, Janet McParland Inspection Team Lead (#142) was on site.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **2 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	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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that drugs are stored in an area or medication cart that is secured and locked.

On December 8, 2015, Inspector #622, observed two prescription creams for Resident # 028, sitting on the vanity in the shared washroom of room 46.
On December 16, 2015 Inspector # 624 observed two prescription creams for Resident #031 stored in a basket on resident's bedside table in Room 58.
On December 18, 2015, Inspector #624 also observed two prescription creams for Resident #028, sitting on the vanity in the shared washroom of room 46.

A review of the physician orders for both Residents revealed no orders permitting the medication to be stored in the Residents' room or washroom. A review of the Home's Medication Policy – General Guidelines stated "Medications are to be stored in locked cabinets/carts at all times, the medication nurse is to lock the medication or treatment cart when not assessing it"

In an interview with RPN Staff #129, she stated that the Home's expectation with prescription topical creams is that the creams should be locked in the treatment cart when not being administered. The only exception, she said, was for Residents who can self administer and there is usually a physician order permitting the Resident to have the medication safely stored in their room. RPN also confirmed that Resident #028 could not self administer the identified creams.
In an interview, the DOC confirmed that prescription topical creams are only kept at the Resident's bedside if there is an order and only if the resident self administers the cream. Otherwise, the medication needs to be stored in a locked cabinet or cart at all times as per the Home's policy. [s. 129. (1) (a)]

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 in ensuring that prescription creams are stored in an area that is secure and locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On December 8, 2015, the following unlabelled items were noted in shared washrooms:

room 46; "secret" deodorant, Crest tooth paste, make up, a bar soap, Dawn Mist tooth Paste (inspector #622)

room 25 two unlabelled tooth brushes on the counter in the shared washroom (inspector#622)
room 25 a basin was unlabeled and on the floor beside the toilet and two toothbrushes unlabeled and on the counter of the bathroom (inspector #623)

room 2; an unlabelled hair brush was noted on the counter of the bathroom (inspector#623).

room 8; three bars of soap were noted on the bathroom counter, two were in an unlabelled soap dish, one was sitting at the side of the sink, an unlabelled denture cup with an unlabelled toothbrush in it and an unlabelled hairbrush were also noted on the bathroom counter (inspector #623).

room 19; unlabelled green basin, containing two toothpastes, three toothbrushes in a holder, one black comb, four folded face cloths (two wet). There was an unlabelled white male urinal hanging on the wall mount bed pan holder (Inspector #626).

room 10, one used Natural Concepts body wash, one used Professional Care body lotion, two used deodorant sticks and eight wash cloths on the counter in the residents' bathroom unlabelled (Inspector # 626)

room 20, one used toothpaste, three toothbrushes, one used Dove body wash, a used Professional Care lotion and one box of Q-tips unlabelled on the washroom counter.

There was one towel hanging on the towel rack. It was noted that the towel racks did not have designated resident names (Inspector # 626).

room 1, one white bed pan was observed placed between the grab bar and counter and one pink bed pan was noted on the floor under the counter in the bathroom (Inspector #626).

room 61; Two used and unlabelled identical toothbrushes on the counter, a used and unlabelled urine hat and urinal placed on the top of the storage cabinet and a soaker pad placed on the floor in front of the toilet bowl (Inspector # 624).

room 66; two unlabelled toothbrushes in a Carlsberg glass on one side of the sink counter (Inspector # 624).

On December 10, 2015 Inspector #623 interviewed PSW#100 who stated that PSWs are to label residents personal items when they are admitted to the home. She further indicated that they are to check personal items, such as toothbrushes, dentures cups and hairbrushes, when they are providing care to make sure that they are labelled.
On December 11, 2015 Inspector (#622) conducted an interview with PSW (#106) who indicated that everything such as personal items are in the top drawer of the residents bed side table in a basket which is labelled, the items are taken to the washroom and tub room and returned back to the top drawer by the persons performing the care. PSW (#104) also stated that all personal care items are supposed to be labelled.

On December 10, 2015 Inspector #623 interviewed RPN #101 who revealed that the homes expectation is that PSWs would label resident's personal items when they are admitted. She indicated that any new items brought in would be labelled as it arrived, if the staff were aware of it. RPN #101 further indicated that residents who share a bathroom should have a dedicated and labelled side of the counter that they place their labelled items on. If the resident requires assistance then the staff usually keep the personal items in the residents bedside table and take out when they use them.

On December 10, 2015 Inspector #623 interviewed RN #102 who stated, the homes expectation is that all items are labelled.

On December 11, 2015 Inspector (#622) conducted an interview with RPN (#105) who stated that when residents are first admitted everything is labelled, then on an ongoing

basis things are labelled by staff.

On December 11, 2015 Inspector (#622) conducted an interview with, RN (#108), who is the Infection control lead and confirmed that personal items should be labelled.

On December 15, 2015, during the Medication Administration observation, Inspector #624 observed Staff #101 while administering a medication. Resident #044 had a contact precautions sign posted on the door. The RPN was not observed performing hand hygiene before entering in residents' room, and was not observed wearing gloves at the door before entering room. Staff observed performing hand hygiene after administering medication and exiting room.
When asked on the expectation with regards to infection prevention and control, staff member indicated that the resident returned from the hospital and was put on precautionary contact precaution until he/she is cleared of not having any MRSA or VRE. She stated that the expectation is to follow the contact precautions procedure when providing personal care. However, staff later indicated that the staff member should have followed the homes policy of performing hand hygiene and donning gloves and possibly gown before going into resident's room to administer the medication.

Therefore the licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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 in ensuring that as part of the homes infection prevention and control protocol, staff participate in the implementation of the program by ensuring, resident personal care items located in shared accommodations are labelled, staff perform hand hygiene and wear the Personal Protective Equipment according to direction, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to comply with the Home's Skin Care Program, Section - Skin Care and Pressure Ulcer Management Program.

As per Ontario Regulation 79/10 s. 48. (1) (2), every licensee of a long-term care home shall ensure that they develop and implement in the home, an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

A review of the Home's Skin Care Program, Section - Skin Care and Pressure Ulcer Management Program with effective date of July 1996, last reviewed January 2013, states for Pressure Ulcer: "Reassess Ulcer Weekly and Document the following: stage, location, size, odour, and condition of skin at base and at edges of open area"

Resident #031 was admitted to the home on a specified date with a pressure ulcer. Upon review of Resident #031's progress notes and the treatment sheets from admission to December 14, 2015 there was no indication of weekly assessments of the pressure ulcer. In an interview with RPN S #105 on December 12, 2015 regarding the home's policy on skin and wound, RPN stated that every resident receives a skin assessment on admission, and quarterly thereafter or as needed. She further indicated that it is the Home's expectation that pressure ulcers should be assessed weekly and that the assessments are documented in the progress notes. The RPN indicated that Resident #031 has a pressure ulcer. The RPN was unable to locate the weekly assessments. In an interview with the DOC on December 14 and 15, 2015, the DOC confirmed that assessments are to be done weekly and documented in the progress notes. DOC confirmed that she has reviewed Resident #031's progress notes and was unable to find any weekly assessments and documentation pertaining to the pressure ulcer. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The license has failed to ensure that when restraining a resident with a physical device the licensee has satisfied the requirement of the LTCA s. 31. (2) 1 – 5.

Resident # 008 was observed on December 08, 14, 15 and 16, 2015 sitting in the residents' wheelchair with a front closure seat belt applied. The resident was asked on December 14 and 16, 2015 to remove the seat belt but he/she was unable. On December 16, 2015 PSW #115 asked the resident to remove the seatbelt and he/she was unable. The RPN # 101 was interviewed on December 16, 2015 and confirmed that no physician order, consent or monitoring document were found in Resident # 008's health records. During an interview with the Director of Care (DOC) on December 16, 2015, it was confirmed that the resident should not have a restraint and should not be wearing the seat belt. [s. 31. (2) 5.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident the body mass index and height upon admission and annually thereafter.

During the health records review conducted by inspectors #622, #623, #624 and #626 during Stage 1 of the RQI, it was noted that not all the Residents had their height recorded annually.
The following Residents had last recorded heights taken on the corresponding years below:
Resident #012 in 2006, Resident #001 in 2009, Residents #017, #024, #034 in 2011, Residents #008, #011, #014, #019, #028 in 2012, Residents #002, #005, #021, #022, #033, #038 in 2013, and Residents #007, #010, #016, #018, #025, #026, #035 in 2014.
In an interview with RPN Staff # 129, RPN stated that heights were taken on admission and at no other time except when ordered by a physician or if the information is missing from the chart. The Dietitian on interview said heights were taken on admission but was unsure of whether they should be taken annually.
In an interview with the DOC, she stated that the home's expectation is that heights are taken on admissions and then annually thereafter during the residents' yearly physical assessments to be completed by the nurses. [s. 68. (2) (e)]

Issued on this 24th day of December, 2015

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

Original report signed by the inspector.