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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Sep 13, 2016	2016_272641_0008	013489-16	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

CATHI KERR (641), AMBER LAM (541)

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): September 8, 9, 12, and 13, 2016

During this Resident Quality Inspection (RQI), two critical incident inspections were also conducted.
Log #007311-14 and Log #027314-15, both involving a resident who had fallen and sustained an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support
Workers (PSW); Residents; Residents' Council President; Family Council member; Resident's Family members.

Inspectors also reviewed the following: resident health care records; observed resident rooms and common areas; observed resident care and services; reviewed the minutes of the resident council; skin and wound program; the home's medication administration process.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

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

1 WN(s)
0 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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of:
ii. supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

While conducting resident observations on a specified date, Inspector #541 noted that resident #19's wheelchair seat belt had a large amount of dried food on it. Four days later, Inspector #541 again observed resident's seat belt to have the same food debris that was present the previous week.

On a specified date, resident #20's walker with a cushioned seat was noted to have a large amount of food debris. During observations made again four days later, the same food debris was present on the walker.

Inspector confirmed with the home's Director of Care (DOC) that each unit has a schedule to be followed for cleaning of ambulation equipment and each resident's equipment should be cleaned 1-2 x per month as per that schedule. Upon review of the schedule it was noted that resident #19's walker was not signed off as being cleaned as scheduled for the previous Friday. Resident #20's walker was signed off as cleaned last on the previous Saturday.
The DOC stated it would be her expectation that the wheelchair and/or walker be cleaned as per the schedule and also as needed.

The Personal Support Worker (PSW) shift routine for the 2300-0700 hour shift was provided to Inspector #541. The shift routine states that PSW's are to "carbolize w/c, gerichairs, walkers, bed pans, commodes, soap dishes, K basins, etc according to the assigned list kept in the cleaning book at each reception".

The home's DOC observed resident #19's wheelchair seat belt and resident #20's walker and was able to confirm that they required cleaning.

The home failed to implement their procedures for cleaning of personal assistance services devices as resident #20's wheelchair seat belt and resident #19's walker were observed to be soiled with the same stains and/or debris on two dates four days apart. [s. 87. (2) (b)]

Issued on this 14th day of September, 2016

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

Original report signed by the inspector.