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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2017	2017_589641_0034	022104-17	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), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 16, 17, 18, 19 and 20, 2017.

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Health and Safety and Quality Improvement Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family council president, resident council president, family members, and residents.
During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, the home's staffing schedules for the nursing department, and the licensee's policies related to restraints and medication administration.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During a review of the home's medication incidents that occurred between a specified three month period, Inspector #602 noted the following medications were not given in accordance with the physician's order:
- On a specified date, resident #022 received twice the prescribed dose of a controlled substance.
- On two specified dates, resident #024 did not receive the evening dose of their medication.
- On a specified date, resident #012 did not receive the prescribed dose of a controlled substance.
- On a specified date, resident #026 did not receive the prescribed dose of a controlled substance.
- During a specified 10 day period, resident #027 did not receive multiple doses of a prescribed medication. The medication incident report indicates a pharmacy error was responsible for the error(s).
All of the above noted medication incident reports were reviewed and there was no noted negative impact on the residents as a result of the errors.

The licensee failed to ensure that drugs were administered to residents #'s 022, 024, 012, 026, and 027 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident' s substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The Director of Care (DOC) was interviewed on October 19, 2017 regarding the home's process for documenting medication incidents that have occurred in the home. A review of the medication incident reports provided by the DOC for a specified three month period revealed that many of the incident reports did not include documentation as to the assessment of the resident following the medication incident, nor did they indicate that the resident and/ or his/her substitute decision maker (SDM)/Power of Attorney (POA) were notified. The DOC acknowledged that the post incident resident assessments were not well documented and that the physician and the resident and/or SDM/POA weren't always notified. The DOC indicated that they will look to establishing better documentation and notification processes specific to medication incidents.

During the review of twelve (12) medication incidents that occurred during a specified three month period, it was noted that seven (7) of the 12 medication incidents did not include documentation to reflect the immediate actions taken to assess and maintain the resident’s health. The inspector also found that four (4) of the 12 incidents included no documentation to reflect the required notification of the resident and/or the SDM/POA and a further ten (10) of the 12 incidents included no documentation to reflect the required notification(s) of the physician(s). [s. 135. (1)]

WN #3: 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 O. Reg. 79/10, s. 229 (4).

On October 16, 2017, an initial tour of the home was conducted. Observations of each of the reception units tub/shower/spa rooms were conducted and concerns specific to the home's nail care equipment cleaning process were identified in that the sanding band on the dremel used for foot care in the reception 3 Spa area was coated with white debris and no new replacement sanding bands were identified in the foot care treatment area.

In an interview on October 20, 2017, the foot care RN #116 indicated that the sanding bands were not replaced before use on the next resident requiring foot care. The RN noted that attempts were made to wipe off the sanding band before use on the next resident if a significant amount of debris had collected, however, alcohol swabs tended to rub away the grit rendering the sanding band ineffective. The sanding bands were only replaced once too much of the grit required for sanding had been lost. Inspector #602 asked if there were concerns regarding cross contamination occurring between residents receiving foot care. RN #116 agreed it could occur as the same sanding band was used on multiple residents. The foot care RN indicated that she had not reviewed this practice with the Health and Safety and Quality Improvement Coordinator (HSQI) #105 or the infection control nurse, but that she would alert the DOC as to the concern that morning. An interview with the HSQI #105 revealed that it was assumed that the sanding bands would be replaced before use on another resident. RN #116 advised later that morning that she had reviewed the potential for cross contamination with the home's DOC and additional sanding bands had been ordered. The RN further advised that new sanding bands would be used at each foot care session on only one resident. Once the foot care was completed, the used band would be discarded and a new band would be used with the dremel for the next resident. [s. 229. (4)]

Issued on this 24th day of October, 2017

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

Original report signed by the inspector.