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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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 7, 2013	2012_184124_0012	O-002329-12	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

LYNDA HAMILTON (124)

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 18, 20 & 21, 2012.

This inspection included two complaints, log numbers O-002329-12 and O-002393-12.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, five Registered Practical Nurses and six Personal Support Workers.

During the course of the inspection, the inspector(s) observed medication administration, reviewed resident health records including plans of care, medication administration records, progress notes, pain assessment, KGH Emergency Department Records, Staff Time Sheet,Discharge from Hospital Summary,Medical Certificate of Death and the following policies and procedures; Medication Policy-General Guidelines, Drug Administration-Preparation, Administration and Documentation, Tub Bath/Shower.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Medication

Pain

Personal Support Services

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.36. in that the staff did not use safe transferring and positioning techniques when assisting the resident in the tub room as evidenced by the following finding.

Resident #1 was a resident with diagnoses of Cerebral Vascular Accident.

The home submitted Critical Incident Report #2728-000022-12 to advise the Ministry of Health and Long-Term Care that there had been an injury that resulted in transfer to hospital because of a resident fall in the tub room.

Staff member #S109 reported to the inspector that she had raised Resident #1 out of the tub and lowered the resident to staff member #S109's waist level. She began to provide personal care to Resident #1. When staff #S109 had finished what she could do alone and was waiting for assistance from staff #S110, she proceeded to the head of the tub and began to raise the tub so it would drain more effectively. Resident #1 was still positioned at the height of staff #S109's waist so Resident #1's feet were not on the floor. The tub caught the chair and the chair went over, sending Resident #1 to the floor.

Staff members #S107, #S108 and #S110 confirmed that they had been trained to have the residents at waist height to provide personal care before lowering the resident to the floor. They would then request assistance from the other bath team member.
The Director of Care reported that the staff was not following the home's policy for safe transfers because there were to be two staff with the resident until the resident's feet were on the floor. The home's policy is and has been two staff for all lifts and transfers.

Resident #1's progress notes reported that the resident was sent to hospital and returned to the home the same evening.
Resident #1 passed away fourteen days later and the immediate cause of death is listed as lacerations and bruise from fall.

This finding relates to log O-002329-12. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 failed to comply with O.Reg. 79/10, s. 131. (2) in that drugs were not administered to residents in accordance with the directions for use specified by the prescriber as demonstrated by the following findings.

Resident #3 has a diagnosis of diabetes and the physician ordered insulin at breakfast.
On a specific date, staff member #S100 reported to the inspector that she was late in administering Resident #3's insulin; the resident did not received the insulin until 0930 hours, after the resident was finished breakfast.

Resident #4's physician prescribed a specific medication, one tablet before breakfast and supper and 1/2 tablet before lunch.
On a specific date, staff member #S101 confirmed that Resident #4 did not receive the medication until 0958 hours. Resident #4 had finished breakfast and was in the Activity Room when he/she received the medication.

These findings relate to log O-002393-12. [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 medications are administered to residents in accordance with the directions specified by the prescriber, to be implemented voluntarily.

WN #3: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, s. 3. (1) 11. i. in that the resident did not participate fully in the review and revision of the resident's plan of care as evidenced by the following finding.

On a specific date, the following is documented in the progress notes:
- that Resident #1 was returning to the home from hospital. Resident #1's medication reconciliation was completed and the decision was made to discontinue a specific medication.

-that at 1900 hours, the resident arrived at the home accompanied by a nurse from Kingston General Hospital (KGH). The nurse from KGH reported that Resident #1's specific medication was due at 1845 hours. The nurse was advised that this medication had not been re-ordered.

-that Resident #1's Power of Attorney for Personal Care reported that she wanted the physician contacted immediately.

Resident #1's Power of Attorney for Personal Care advised the inspector that she had not been consulted regarding the decision to discontinue Resident #1's specific medication.

This finding relates to log O-002329-12. [s. 3. (1) 11. i.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, c.8., s. 6. (1)(c) in that the resident's plan of care did not provide clear direction to staff.

Resident #2 has a diagnosis of Cerebral Vascular Accident.

Resident #2's plan of care, under "Eating" identified that the resident had high risk of choking and to ensure the head of the bed (HOB) is elevated.

The Director of Care confirmed that Resident #2 should have the head of the bed elevated to at least forty-five degrees because of the resident's history of swallowing difficulties and choking.

On a specific date, staff #S101 reported to the inspector that Resident #2 always takes the medication in applesauce. She also stated that Resident #2 was in bed for the 1400 hours dose of medication and she raised the head of Resident #2's bed thirty degrees and prepared to administer the medication. The resident's family member requested the resident be higher, so staff #S101 raised the head of the bed higher and administered the medication. Staff #S101 reported that the resident was fine taking the medication.

On the same day, staff #S102 reported to the inspector that she ensures that Resident #2 is at a sixty to eighty degree angle when in bed and receiving medication.

Two days later, staff #S103 reported to the inspector that she raises the head of Resident #2's bed to a forty to forty five degree angle when administering the resident's medication.

These findings relate to log O-002393-12. [s. 6. (1) (c)]

Ontario

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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

Issued on this 31st day of January, 2013

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

Lynda Hamilton

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2012_184124_0012
Log No. / Registre no:	O-002329-12
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 7, 2013
Licensee / Titulaire de permis :	GIBSON HOLDINGS (ONTARIO) LTD 343 Amherst Drive, Amherstview, ON, K7N-1X3
LTC Home / Foyer de SLD :	HELEN HENDERSON NURSING HOME 343 Amherst Drive, Amherstview, ON, K7N-1X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA GIBSON

To GIBSON HOLDINGS (ONTARIO) LTD, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that staff use safe transferring and positioning techniques when assisting residents in the tub room.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg. 79/10, s.36. in that the staff did not use safe transferring and positioning techniques when assisting the resident in the tub room as evidenced by the following finding.

Resident #1 was a resident with diagnoses of Cerebral Vascular Accident.

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Resident #1's progress notes reported that the resident was sent to hospital and returned to the home the same evening.
Resident #1 passed away fourteen days later and the immediate cause of death is listed as lacerations and bruise from fall.

This finding relates to log O-002329-12. [s. 36.] (124)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of January, 2013

Signature of Inspector / Signature de l'inspecteur : Lynda Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

Service Area Office / Bureau régional de services : Ottawa Service Area Office