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
Apr 12, 2013	2013_184124_0003	O-002430-12, O-000083-13	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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 5-7, 12-14, 2013.

This inspection was conducted related to three complaints with log numbers O-002430-12, O-000083-13 and O-000100-13.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, Nurse Practitioner, three Registered Nurses, three Registered Practical Nurses, five Personal Support Workers, laundry, housekeeping and maintenance staff and a technician from one of the home's vendors.

During the course of the inspection, the inspector(s) observed resident dining, reviewed resident health records, the home's policy regarding transferring residents , Resident Equipment Service Logs for Weekly Service and the Instructions for Use of the BHM Medical V3 lift.

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

Dining Observation

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 73. (2)(b) in that residents who require assistance with eating or drinking were served a meal before someone was available to provide assistance.

On February 12, 2013, from on or about 1655 hours until 1835 hours the evening meal was observed and the following observations were made:
Resident #4's plan of care stated that staff was to assist with constant cueing and guidance during meals. On January 18, 2013 there is documentation by a Registered Nurse that indicated Resident #4 has had continued weight loss. Resident #4 was served the evening meal on or about 1738 hours; the meal was not within reach and the resident was observed to be looking around the dining room, as if looking for assistance. Twenty minutes later, staff #100 sat down to assist Resident #4. Resident #4 took several bites and then did not want to eat the meal. Staff #100 confirmed that the resident's meal was cold. Staff #100 did not make any further attempts to encourage intake including offering food items that the resident is known to enjoy.

Resident #5 is cognitively impaired and was assessed as requiring one person to physically assist with feeding. It is documented that Resident #5 had inadequate food/fluid consumption and has a dietary supplement prescribed. Resident #5's family member expressed concern about the decrease in the resident's nutritional intake. Resident #5's evening meal was served on or about 1730 hours and at 1735 hours staff #101 offered the resident a beverage. Staff #101 then proceeded to assist Resident #6 who was seated at the same table. Eight minutes after the food was served, Resident #5 was offered assistance by staff #101. Resident #5 ate several bites and staff #101 was then called from the table. At this time, Resident #5 had three quarters of the meal remaining. Several minutes later, Staff #102 came to assist Resident #5 who was no longer interested in eating. Staff #102 did not offer the resident the alternative meal or any food items the resident is known to enjoy. At 1800 hours staff #102 left Resident #5 to go on break. At this time, Resident #5 began to complain and the resident repeatedly called out.

A table of four residents all of whom were assessed as requiring total assistance with feeding received their evening meal on or about 1730 hours. Five minutes later, a staff member proceeded to assist two of the residents while the other two residents, Residents #7 and #8 continued to wait with their dinners in front of them. Resident #7 had identified weight loss in January 2013 and is identified as a risk level four. Resident #8 was assessed as moderate nutritional risk. At 1740 hours, staff #100

came to the table and assisted Residents #7 & #8 who were still waiting to eat their dinners.

Resident #10 was served dinner on or about 1725 hours and at 1735 hours, Resident #10 received assistance with the meal. Resident #10 was assessed as requiring the extensive assistance of one person for meals and is at moderate nutritional risk. [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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, s. 6. (2) in that the resident's plan of care was not based on the resident's preferences.

Resident #3 is a cognitive resident who clearly expressed a preference regarding personal care.
Resident #3 described an incident where the preference regarding personal care was not followed.
On a specific date, there is documentation in the resident's progress notes that the resident was upset when the preference was not followed.
The Director of Care reported to the inspector that the resident is not always consistent in expressing preferences related to personal care.
Resident #3's plan of care does not identify the resident's preference related to personal care.[s. 6. at 1755

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s.90 (2) (a) in that the home's procedures did not ensure that the portable mechanical lifts were maintained and cleaned at a level that meets manufacturer specifications as demonstrated by the following findings.

-The home uses a BHM Medical V3 portable lift for transferring residents. It is documented in Resident #1's health record that on a specified date the resident was being transferred by two staff via lift and somehow the lift malfunctioned and the resident fell into the chair and the lift portion fell on the resident.
-The home has a procedure "Mechanical Lifts-Safety Precautions" that states all maintenance is to be completed by authorized technicians only.
-The Manufacturer's Specifications for the BHM Medical V3 Lift were provided to the inspector by the Director of Care.
-The manufacturer's specifications for the BHM Medical V3 lift under the Preventive Maintenance Schedule state "the equipment is subjected to wear and tear, and the following maintenance instructions must be acted upon when specified to ensure that the equipment remains within its original manufacturing specifications. Care and maintenance must be carried out in accordance with the preventive maintenance schedule below."
-The Preventive Maintenance Schedule indicates that the BHM Medical V3 lift is be inspected by an authorized service technician who will carry out a number of actions/checks on an annual basis and will replace the strap every two years.
-The Director of Care reported that a technician from one of their vendors is the authorized technician that repairs the home's BHM Medical V3 lifts.
-The technician stated that he is the Motion Specialty staff member who fixes and installs the portable lifts at Helen Henderson. He responds to calls from the home regarding portable lifts that are broken. He reported to the inspector that Motion Specialties does not have a preventative maintenance contract with Helen Henderson with regard to portable lifts.
-The home is not meeting the manufacturer's specifications for the BMH Medical V3. [s. 90. (2) (a)]

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Issued on this 26th day of April, 2013

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

Linda Hamilton