



**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 rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 25, 2016	2016_270531_0035	029251-16, 029477-16	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

SUSAN DONNAN (531)

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): October 4 and 5, 2016.

The following logs were completed concurrently:

Log #029477-16 related to pest control

Log #029251-16 related to falls prevention

During the course of the inspection, the inspector(s) spoke with residents, residents' Substitute Decision Makers, Personal Support Workers (PSW), Registered Practical Nurse, Registered Nurses, the Food Service Supervisor, a Dietary Aide, a Physician, the Assistant Director of Care, the Director of Care and the Administrator.

During the inspection the inspector reviewed resident health care records, observed resident care and services and reviewed appropriate policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Falls Prevention

Reporting and Complaints

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services
Specifically failed to comply with the following:

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
 - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
 - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**



Findings/Faits saillants :

1. The licensee has failed to ensure that the home furnishing and equipment are maintained in a safe condition and in a good state of repair.

In reference to log # 029477-16

On October 5th, 2016 at 1130 the inspector observed the following disrepair in the kitchen and attached servery area:

- servery flooring torn, lifted with pockets of debris in the area of the preparation tables.
- servery baseboard heavily scarred covered in a black thick film.
- the main kitchen food preparation area the large steam table outlet drain appears to be clogged forcing food debris upwards into the drain, drain water pooled around the outside of the drain.
- kitchen equipment such as the stand alone stainless steel rational oven the right outside wall of the stainless steel is blackened and blistered.

On October 5, 2016 the Inspector and the Administrator toured the kitchen and attached servery. The Administrator indicated at that time that the identified areas were not in a good state of repair and required maintenance. [s. 15. (2) (c)]

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 the equipment in the kitchen and attached servery area are maintained in a good state of repair, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #001's plan of care was provided as specified in the plan pertaining to fall prevention.

In reference to Log # 029251-16:

Resident #001 diagnoses included multiple disease diagnosis.

Review of resident #001's plan of care for falls prevention indicated the following interventions:

- mattress alarm in recliner and in bed
- personal alarm applied when resident up in wheelchair
- staff to ensure that alarm is in place and in working order.
- hourly checks.

PSW #100 was interviewed on October 4, 2016 and she indicated that on an identified date she was in the hall and heard resident #001 calling "help me, help me". She indicated that she found resident #001 lying on the floor with his/her wheelchair behind the resident. PSW #100 indicated that resident #001 was seated in his/her wheelchair when she provided the resident with an afternoon snack just minutes before.

PSW #100 indicated that resident #001's personal alarm was not applied as specified in the plan of care.

Later the same day RPN #101, #102 and RN #103 indicated that they responded to assess resident #001 and indicated that resident #001's personal alarm was not applied as specified in the resident's plan of care.

Subsequently the Director of Care was interviewed and indicated that resident #001's personal alarm was not applied as specified in the resident's plan of care and that the incident had been reviewed and actions taken. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production



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Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,

(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :



1. 1. The licensee has failed to ensure that the cleaning schedules for all the equipment; and a cleaning schedule for the food production, servery and dish washing areas are complied with.

In reference to Log # 029477-16

On October 5, 2016 inspector #531 observed the following:

- the linoleum floors in the kitchen and attached servery area the linoleum was extremely sticky.
- white linoleum toward the back of the kitchen had a brown film built up in the flooring texture.
- the attached servery, the flooring edges surrounding the servery cupboards and steam tables were littered with food particles, bread crusts, visible brown debris, bread twist ties, tags and other visible debris.
- the white baseboard along the wall where the refrigerator system is was covered in a black film.
- the inside edge of the rational oven door ledge was filled with yellow curd like food waste along the width of the door ledge.
- the kitchen stove elements contained a build up of grey/black ash like food/waste debris.
- the large floor drain (approx. 5x6 inches)in the preparation area was covered in food/waste debris.

On October 5, 2016 Dietary Aide #110 was interviewed and indicated that the kitchen and attached servery area floors are scheduled to be swept and mopped in the evenings and deep clean is scheduled monthly. She indicated that the current schedule has not been complied with as visibly evident in the kitchen and servery areas.

Inspector #531 toured the kitchen and attached servery area and reviewed the current cleaning schedule with the Administrator and the Foods Services Manager. The Administrator and Foods Services Manager indicated during an interview with Inspector #531 that the current cleaning schedules for all the food preparation system was not complied with . [s. 72. (7)]



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Issued on this 25th day of October, 2016

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

Original report signed by the inspector.