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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 4, 2018	2018_589641_0015	009074-18	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), SUSAN DONNAN (531), 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): May 9, 10, 11, 14, 15, 16, 17, 18, 22, 23 and 24, 2018.

The following logs were inspected in conjunction with the RQI: complaint log #008545-18 related to resident care and critical incident log #009710-18 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activation Coordinator, Activity Aides, Physiotherapist, Resident Council and Family Council representatives, 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, observed dining, reviewed resident health care records, observed and reviewed infection control practices, reviewed Resident and Family Council minutes, policies related to abuse, falls prevention and restraints, the licensee's staffing schedules for the nursing department, and the relevant documents related to bed entrapment.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

9 WN(s)
3 VPC(s)
2 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, that residents were assessed and his or her bed system is evaluated in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During the inspection, inspector #602 observed resident #012 had a "bed assist rail". The rail had an inside opening of forty-three centimeters by forty-eight centimeters with extensions that were slipped under the mattress and then secured to the bed by means of zip ties to the bed frame. The upper portion of the rail was covered in a protective black foam. Staff were interviewed and indicated the rail was used as a means to assist resident #012 with bed mobility and that the rail had been provided by family shortly after admission. The resident's hard copy and electronic health care records were reviewed and there was no documented evidence of assessment related to the use of this rail for resident #012.

On August 21, 2012, a notice was issued to the Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes" and contained a companion document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long-Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team

over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. The guidance document further emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered. Where bed rails are considered for transferring and bed mobility, it recommended that discussions needed to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. The final recommendation was to document whether bed rails were required or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The Director of Care (DOC) was interviewed and indicated no awareness of the Health Canada document related to bed system assessments and bed rail safety. The DOC advised that the last evaluation of the "all resident bed systems in the home for resident entrapment risk", was completed on a specified date, three and half years prior and that the next assessment was booked during the next month. The DOC further indicated that since the majority of bed systems had failed i.e. entrapment concerns in zones 2, 3, 4 and 7, the home's priority has been purchasing replacement bed systems. According to the Joerns document fifty-three bed systems, fifty-one percent of beds in the home, still required replacement.

The decision to issue this non-compliance as an order was based on the following: The scope was assessed as a pattern due to the number of residents requiring new bed systems/rails. The severity was assessed as potential for harm given the home's failure to perform annual evaluations following the prior bed system evaluation as well as the failure to assess the bed assist rail for resident #012 specifically. The home's compliance history was reviewed and the home did not have any similar findings of non-compliance. [s. 15. (1) (a)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents #021 was protected from physical and verbal abuse.

The Long-Term Care Home Act, 2007, defines resident physical abuse as: "the use of physical force by anyone other than a resident that causes physical injury or pain," The Act defines verbal abuse as: "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

The following finding is related to log #009710-18.

Resident #021 was admitted to the LTC home on a specified date with multiple diagnoses. The resident's status requires that time be allowed for processing information. Resident #021 requires total assistance by two staff for transfers and can be resistive to care.

On a specified date, PSW staff #107 and #129 were alerted that resident #021 needed care by an oncoming PSW staff #130 who followed PSW #107 and #129 into resident's #021's room. PSW #107 indicated that PSW #130 took charge and directed them that they needed to boost the resident up in bed. PSW #130 was reported to have boosted the resident up so aggressively that it caused injury to the resident. The resident subsequently began hitting out, resulting in PSW #130 making derogatory comments toward the resident.

PSW #107 and #129 failed to report the incident, later explaining they were in shock and forgot reporting requirements. Upon return to the home the next day, the PSW's asked a co-worker if the incident should be reported and to whom. The co-worker advised that they should have notified the registered nurse (RN) to the incident when it occurred and that they needed to alert the charge nurse, RN #131, right away. PSW's #107 and #129

then reported the previous evening's incident to RN #131.

Upon being alerted to the incident RN #131 immediately reported the incident to the ADOC and completed a head to toe assessment of resident #021. The ADOC was alerted, the PSW suspected of abuse was directed not to return to work until further investigation; the resident's family, the physician, the police, Administrator and the Director were immediately notified.

The delay in reporting by PSW #107 and #129 resulted in the following additional non-compliances:
LTCHA, s. 23 (1)-failing to immediately investigate and act on witnessed incident of abuse.
LTCHA, s. 20 (1)-failing to ensure the written policy to promote zero tolerance of abuse was complied with whereby two staff failed to report the incident to management.
LTCHA, s. 24 (1)-failing to ensure a person who witnessed abuse involving a resident immediately reported the incident to the Director (MOHLTC).
LTCHA, r. 97 (1)-failing to ensure immediate notification of Substitute Decision Maker (SDM)

The scope was assessed at a level one: isolated, given that there had been no similar incidents. The severity was assessed at a level three: actual harm, as staff witnessed resident #021 being injured, as well as heard the derogatory comments. The home's compliance history over the past three years was reviewed and was as follows:
- March 2017: 1 written notification (WN) was issued under LTCHA, 2007, s. 24 (immediately reporting alleged abuse/neglect to the Director),
- September 2015: 1 written notification (WN) was issued under LTCHA, 2007, s. 24 (immediately reporting alleged abuse/neglect to the Director).

Upon considering all of these factors a compliance order will be issued. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's zero tolerance of abuse and neglect policy was complied with.

The following finding is related to log #009710-18.

As outlined in WN #2, a witnessed incident of alleged staff to resident abuse involving resident #021 was not immediately reported to management by PSW #107 and/or PSW #129 outlined in the home's abuse policy.

The home's "Zero tolerance for Resident Abuse and Neglect Policy", last revised April 2018, was reviewed and indicates that employee reporting responsibilities include: "If you witness any action related to abuse and/or neglect in the workplace, you must immediately report the incident to a member of management".

PSW #107 and #129 who witnessed an incident of alleged verbal and physical abuse involving resident #021 failed to immediately report the abuse to the charge nurse on a specified date. [s. 20. (1)]

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 their Zero Tolerance for Resident Abuse and Neglect Policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutritional care and hydration program included a weight monitoring system to measure and record, with respect to each resident, their height on admission and annually thereafter.

A health care record review was completed on 40 residents. It was noted by the inspection team that not all residents had a documented annual height. The following residents did not have a documented height taken during the last year.

1. Resident #028
2. Resident #013
3. Resident #037
4. Resident #038
5. Resident #007
6. Resident #024
7. Resident #027
8. Resident #021
9. Resident #026

10. Resident #003
11. Resident #001
12. Resident #035
13. Resident #039
14. Resident #020
15. Resident #010
16. Resident #015
17. Resident #036
18. Resident #016
19. Resident #005
20. Resident #014
21. Resident #002
22. Resident #025
23. Resident #018
24. Resident #023
25. Resident #034
26. Resident #040

During an interview with Inspector #641 on May 10, 2018 at 1030, the Director of Care (DOC) indicated being aware that not all of the residents had an annual height documented and that some of the residents had not had a repeat height obtained since the resident's admission.

The licensee failed to ensure that residents #001, 002, 003, 005, 007, 010, 013, 014, 015, 016, 018, 020, 021, 023, 024, 025, 026, 027, 028, 034, 035, 036, 037, 038, 039, and 040 had a height obtained annually. [s. 68. (2) (e) (ii)]

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 nutritional care and hydration program included a weight monitoring system to measure and record, with respect to each resident, their height on admission and annually thereafter, to be implemented voluntarily.

WN #5: 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 medications were given to residents #047 and #048 in accordance with directions for use specified by the prescriber.

Resident #047 had a physician's order for a specified medication to be given twice daily. A review of the medication incident report for a specified date, indicated that on that day, resident #047 received the wrong dose of the specified medication at the specified time. The blister packs containing the prescription for resident #047 had stronger dose capsules in it instead of the doses that were ordered. Resident #047 was given the stronger dose capsule from the blister pack and then it was noted that the wrong medication was in each one of the blisters. An assessment was done and there was no ill effect to the resident.

Resident #048 had a physician's order for three specified medications. A review of the medication incident report for the specified date, indicated that on that day, these three medications were signed in the resident's eMAR that they had been given, but the medications had been found in the medication cart still in the strip packaging, indicating that they had not been given to the resident as prescribed. The resident had been assessed and there was no ill effect.

During an interview with Inspector #641 on May 18, 2018 at 1510, the Director of Care (DOC) indicated being aware of the medication incidents that occurred on the specified dates related to residents #047 and #048. The DOC specified that in each of the incidents, the residents did not receive their medications as prescribed by their doctors.

The licensee failed to ensure that medications were given to residents #047 and #048 in accordance with 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 #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The following finding is related to log #009710-18.

The licensee failed to immediately investigate an alleged incident of staff to resident neglect involving resident #002.

As outlined in WN #2, resident #021 was aggressively boosted up in bed by PSW #130 on a specified date; this caused an injury to the resident. PSW #130 then made derogatory comments toward the resident. PSW's #107 and #129 did not report the incident until the next evening, delaying management's ability to immediately begin an investigation. PSW #130 was able to finish working the shift and the shift on the following day, thereby exposing all residents to potential harm by the employee.

The ADOC was interviewed and advised that upon being alerted to the incident RN #131 was directed to complete a head to toe assessment of resident #021. The ADOC contacted the PSW suspected of abuse to advise that they not return to work until further investigation. The resident's family, physician, police, Administrator and the Director were also immediately notified. [s. 23. (1) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following finding is related to log #009710-18.

The licensee has failed to ensure an alleged incident of staff to resident neglect was immediately reported to the Director (MOHLTC).

As outlined in WN #2, on a specified date, resident #021 was aggressively boosted up in bed by PSW #130; this caused an injury to the resident. PSW #130 then made derogatory comments toward the resident. The incident was not reported until the following evening shift delaying management's investigation, allowing the suspected employee to work and thereby exposing all residents to potential harm by the employee.

The ADOC was interviewed and advised that upon being alerted, the PSW suspected of abuse was contacted and advised not to return to work pending an investigation. The resident's family, physician, police, Administrator and the Director were notified approximately twenty hours after the incident. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 32 where by resident #046 did not receive individualized care with oral hygiene on a daily basis.

Resident #046's current plan of care includes specific instructions related to oral hygiene.

On May 18, 2018, during an interview with resident #046's Substitute Decision Maker (SDM), the SDM indicated that resident #046 was not being provided oral hygiene as per the resident's individualized care preference. The SDM indicated that resident #046 was provided oral hygiene care twice a day and that the SDM had provided oral care on multiple occasions when the SDM visited with the resident.

On May 17 and 18, 2018 during separate interviews with inspector #531, PSW #123 and #121 both indicated that they were aware that staff needed to provide assistance for resident #046 to complete oral hygiene. They indicated that resident #046 was not always provided the assistance with oral hygiene as per the resident individualized care with oral hygiene on a daily basis. Both PSWs indicated that resident #046 was guaranteed oral hygiene twice daily, in the morning and evening. PSW #121 indicated that there was not always time to provide the assistance required after meals. PSW #123 specified that there were times that the resident slept in later some mornings and care was provided with morning care, however not always after meals as per the resident's preference.

On the same day, during an interview with inspector #531 and review of resident #046's individualized plan of care in respect to oral hygiene, the ADON indicated that resident #046 had not been provided oral hygiene as per the resident's individualized care. The ADON indicated that they would implement a signage sheet to ensure that the resident received individualized oral hygiene on a daily basis. [s. 32.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The following finding is related to log #009710-18.

The licensee has failed to ensure that resident #021's SDM was notified immediately upon becoming aware of witnessed abuse of the resident that resulted in physical injury, pain and distress that could potentially be detrimental to resident #021's health or well-being.

As outlined in WN #2, resident #021 was aggressively boosted up in bed by PSW #130 causing injury to the resident. The PSW then made derogatory comments toward the resident. PSW's #107 and #129 did not report the incident to the charge nurse, waiting until the next evening to report the incident.

The ADOC was interviewed and advised that upon being alerted, the charge nurse was directed to call the family to notify the SDM; this occurred on a specified date, approximately twenty hours after the physical and verbal abuse occurred. [s. 97. (1) (a)]

Issued on this 25th day of July, 2018

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

Original report signed by the inspector.

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHI KERR (641), SUSAN DONNAN (531), WENDY BROWN (602)
Inspection No. / No de l'inspection :	2018_589641_0015
Log No. / No de registre :	009074-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 4, 2018
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. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s.15 (1).s.6 (7) of the LTCHA.

Specifically the licensee shall ensure the following:

1. Develop and implement a bed safety assessment form for the home that includes all relevant questions and guidance related to bed safety hazards found in the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long-Term Care Home and Home Care Settings (U.S. F.D.A, April 2003) recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008. The questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:
a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternatives were effective or not during an observation period.
2. Create an interdisciplinary team that will assess all residents who use one or more bed rails using the home's bed safety assessment form and document the assessed results and recommendations for each resident.
3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the bed safety assessment form. Include in the written plan of care any necessary accessories that may be required to mitigate any identified bed safety hazards.
4. Revise the bed system/rail replacement plan for remaining failed bed systems to priorize all residents who require one or more bed rails.
5. Develop an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, that residents were assessed and his or her bed system is evaluated in accordance

with evidence-based practices and if there are none, in accordance with prevailing practices, to minimize risk to the resident.

During the inspection, inspector #602 observed resident #012 had a "bed assist rail". The rail had an inside opening of forty-three centimeters by forty-eight centimeters with extensions that were slipped under the mattress and then secured to the bed by means of zip ties to the bed frame. The upper portion of the rail was covered in a protective black foam. Staff were interviewed and indicated the rail was used as a means to assist resident #012 with bed mobility and that the rail had been provided by family shortly after admission. The resident's hard copy and electronic health care records were reviewed and there was no documented evidence of assessment related to the use of this rail for resident #012.

On August 21, 2012, a notice was issued to the Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes" and contained a companion document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long-Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. The guidance document further emphasized the need to document clearly whether alternative interventions were trialled if bed rails were being considered. Where bed rails are considered for transferring and bed mobility, it recommended that discussions needed to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. The final recommendation was to document whether bed rails were required or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The Director of Care (DOC) was interviewed and indicated no awareness of the Health Canada document related to bed system assessments and bed rail

safety. The DOC advised that the last evaluation of the "all resident bed systems in the home for resident entrapment risk", was completed on a specified date, three and half years prior and that the next assessment was booked during the next month. The DOC further indicated that since the majority of bed systems had failed i.e. entrapment concerns in zones 2, 3, 4 and 7, the home's priority has been purchasing replacement bed systems. According to the Joerns document fifty-three bed systems, fifty-one percent of beds in the home, still required replacement.

The decision to issue this non-compliance as an order was based on the following:
The scope was assessed as a pattern due to the number of residents requiring new bed systems/rails. The severity was assessed as potential for harm given the home's failure to perform annual evaluations following the prior bed system evaluation as well as the failure to assess the bed assist rail for resident #012 specifically. The home's compliance history was reviewed and the home did not have any similar findings of non-compliance. (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA.

Specifically, the licensee shall ensure that:

Education is provided to PSW #107, 129 and 130 specific to "Zero tolerance for Resident Abuse and Neglect Policy", last revised April 2018, and related legislation, in addition to annual education, that highlights:
a. Requirements specific to responding (2007, c. 8, s. 23 (1).),
b. Reporting (2007, c. 8, s. 20 (1)., 2007, c. 8, s. 24 (1). and O. Reg. 79/10, s. 97 (1).) and
c. Investigating (2007, c. 8, s. 23 (1).) every alleged, suspected or witnessed incident of resident abuse or neglect by staff.
d. And this education is documented.

Grounds / Motifs :

1. The licensee has failed to ensure residents #021 was protected from physical and verbal abuse.

The Long-Term Care Home Act, 2007, defines resident physical abuse as: "the use of physical force by anyone other than a resident that causes physical injury or pain," The Act defines verbal abuse as: "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident."

The following finding is related to log #009710-18.

Resident #021 was admitted to the LTC home on a specified date with multiple diagnoses. The resident's status requires that time be allowed for processing information. Resident #021 requires total assistance by two staff for transfers and can be resistive to care.

On a specified date, PSW staff #107 and #129 were alerted that resident #021 needed care by an oncoming PSW staff #130 who followed PSW #107 and #129 into resident's #021's room. PSW #107 indicated that PSW #130 took charge and directed them that they needed to boost the resident up in bed. PSW #130 was reported to have boosted the resident up so aggressively that it caused injury to the resident. The resident subsequently began hitting out, resulting in PSW #130 making derogatory comments toward the resident.

PSW #107 and #129 failed to report the incident, later explaining they were in shock and forgot reporting requirements. Upon return to the home the next day, the PSW's asked a co-worker if the incident should be reported and to whom. The co-worker advised that they should have notified the registered nurse (RN) to the incident when it occurred and that they needed to alert the charge nurse, RN #131, right away. PSW's #107 and #129 then reported the previous evening's incident to RN #131.

Upon being alerted to the incident RN #131 immediately reported the incident to the ADOC and completed a head to toe assessment of resident #021. The ADOC was alerted, the PSW suspected of abuse was directed not to return to work until further investigation; the resident's family, the physician, the police, Administrator and the Director were immediately notified.

The delay in reporting by PSW #107 and #129 resulted in the following additional non-compliances:
LTCHA, s. 23 (1)-failing to immediately investigate and act on witnessed incident of abuse.
LTCHA, s. 20 (1)-failing to ensure the written policy to promote zero tolerance of abuse was complied with whereby two staff failed to report the incident to management.
LTCHA, s. 24 (1)-failing to ensure a person who witnessed abuse involving a resident immediately reported the incident to the Director (MOHLTC).
LTCHA, r. 97 (1)-failing to ensure immediate notification of Substitute Decision Maker (SDM)

The scope was assessed at a level one: isolated, given that there had been no similar incidents. The severity was assessed at a level three: actual harm, as staff witnessed resident #021 being injured, as well as heard the derogatory comments. The home's compliance history over the past three years was reviewed and was as follows:
- March 2017: 1 written notification (WN) was issued under LTCHA, 2007, s. 24 (immediately reporting alleged abuse/neglect to the Director),
- September 2015: 1 written notification (WN) was issued under LTCHA, 2007, s. 24 (immediately reporting alleged abuse/neglect to the Director).

Upon considering all of these factors a compliance order will be issued. (641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Cathi Kerr

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