

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

## Original Public Report

Report Issue Date: February 18, 2024	
Inspection Number: 2024-1224-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Gibson Holdings (Ontario) Ltd.	
Long Term Care Home and City: Helen Henderson Nursing Home, Amherstview	
Lead Inspector Erica McFadyen (740804)	Inspector Digital Signature
Additional Inspector(s) Heath Heffernan (622)	

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 8-9, 12-13, 15-16, 2024

The following intake(s) were inspected:

- Intake: #00108324 - PCI

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration  
Medication Management  
Safe and Secure Home  
Quality Improvement

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

Pain Management  
Falls Prevention and Management  
Skin and Wound Prevention and Management  
Resident Care and Support Services  
Continence Care  
Residents' and Family Councils  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Residents' Rights and Choices

## INSPECTION RESULTS

### Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)

Website

s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,

(e) the current report required under subsection 168 (1);

On February 13, 2024 Inspector #740804 was unable to locate the long-term care home's Continuous Quality Improvement (CQI) Report on their website. In an interview with the Associate Director of Care it was confirmed that the CQI Report

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

was not published on the website.

On February 15, 2024 Inspector #740804 confirmed that the CQI Report had now been published to the long-term care home's website.

[740804]

Date Remedy Implemented: February 15, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

On February 8, 2024, Inspector #622 observed hand sanitizer in two separate resident home areas (RHAs) had expired.

A review of the email trail between the Director of Care (DOC) and the Public Health Unit (PHU) dated February 13, 2024, indicated that expired hand sanitizer should not be used.

On February 16, 2024, Inspector #622 observed the Environmental Services Supervisor (ESS) had replaced all outdated hand sanitizer in the home.

[622]

Date Remedy Implemented: February 16, 2024

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

## WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in residents #001, #002 and 003's activity of daily living (ADL) plan of care has been documented.

### Rationale and Summary

Review of the point of care (POC) tasks documentation between February 1 to 11, 2024, related to activities of daily living for residents #001, #002 and #003 indicated that there were omissions in the documentation for the provision of ADL care for each resident as follows:

- Resident #001 - seven dates related to dressing, personal hygiene and oral care that had omissions in documentation.
- Resident #002 - six dates related to dressing, personal hygiene and oral care that had omissions in documentation.
- Resident #003 – eight dates related to dressing, personal hygiene and oral care that had omissions in documentation.

During separate interviews with Inspector #622 on February 16, 2024, Personal Support Workers (PSWs) #107, #108, and #109 stated that residents #001, #002 and #003's care related to ADLs had been provided, however the documentation of the care was not always completed.

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

Failing to ensure that a resident's provision of ADL care such as dressing, personal hygiene and oral care has been documented, can increase the risk of uncertainty whether the care was provided.

Sources: Review of POC task documentation and interview with PSW #107 and other staff.

### WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

### Rationale and Summary

On February 8, 2024, Inspector #622 observed an unnumbered storage room door at the entrance to reception #1 resident home area (RHA), that had a keypad lock on the door and could be opened without using the code. The room contained ceiling lifts, lift slings, an isolation stand, mouth care and skin care supplies. A clean utility room behind the nurse's station on reception #2 RHA, had a keypad lock on the door that could be opened without using the code. The room contained resident

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

charts, dressing trays, wound care supplies, suction, and catheter care equipment. Across from the nurse's station on reception #2 RHA there was a door titled; "Examining Room" that had a keypad lock and could be opened without entering the code. The room contained a treatment cart on which the lock was not functioning and allowed access to multiple resident's prescription treatment creams that were sitting on top as well as in the cart. All three rooms that had doors with non-functioning keypad locks were in areas that were accessible to residents and anyone passing by.

During an interview with Inspector #622 on February 8, 2024, the Director of Care (DOC) indicated that the non-residential doors with keypad locks should not have allowed anyone access without entering the codes.

By having non-residential rooms containing prescription treatments, equipment and supplies with doors that were not kept closed and locked, places residents at risk for injury.

Sources: observation of non-residential doors and interview with DOC and other staff.

[622]

### WRITTEN NOTIFICATION: Safe storage of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

The licensee has failed to ensure that prescription medicated treatments were stored in an area or a medication cart that was secured and locked.

#### Rationale and Summary

On February 8, 2024, Inspector #622 observed on reception #2 resident home area (RHA), that the "examining room" door had a keypad lock that could be opened without entering the code, allowing access to a medication cart that had prescription medicated treatments sitting on top. The medication cart also appeared to be locked however, the lock was not functioning and inside the cart were multiple other prescription medicated treatments.

During an interview with Inspector #622 on February 8, 2024, Director of Care (DOC) indicated that both the "examining room" door keypad and the medication cart locks should function, and the prescription medicated treatments should be kept secured and locked.

By not ensuring that prescription, medicated treatments have been stored in a secure locked area or medication cart places residents at risk for injury.

Sources: Observation of the medication cart and interview with the DOC.

[622]



Inspection Report Under the  
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Ottawa District  
347 Preston Street, Suite 410  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559