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 |
|---|---|---|---|
| Jan 3, 2018 | 2017_589641_0040 | 025622-17, 027391-17, 027768-17 | Critical Incident System |

### 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)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 19, 20, 21 and 22, 2017.**

**This inspection was conducted in reference to two critical incidents Log #027768-17 and Log #027391-17 related to residents falling resulting in injury and Log #025622-17 related to resident care.**

**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), Dietary Staff, and residents.**
**During the course of the inspection, the inspector reviewed resident health care records, observed resident care and relevant policies and procedures related to falls prevention.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Critical Incident Response**
**Falls Prevention**
**Personal Support Services**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):**

**1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).**

**2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).**

**3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).**

**4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).**

**5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).**

**6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).**

**Findings/Faits saillants :**

1. The following finding is related to log #027768-17.

The licensee has failed to ensure that the Director was informed immediately, in as much detail as is possible in the circumstances, when a resident has an unexpected or sudden death, including a death resulting from an accident.

The Licensee submitted a critical incident to the Director on a specified date that indicated that resident #001 had a fall five days prior, that resulted in several injuries to the resident. On a specified date, one day before the critical incident was submitted, the resident was pronounced deceased at the home, as a result of these injuries.

During an interview with Inspector #641 on December 20, 2017, the ADOC indicated that the reason the critical incident was submitted to the Director a day late was because the ADOC had not been notified on the day that resident #001 died. The ADOC indicated that the procedure in the home was that the manager on call was to be notified when a resident died in a circumstance such as this. The ADOC specified that she had been aware that resident #001's death would be a coroner's case since it was a result of a fall where the resident had sustained injuries.

Inspector #641 reviewed the resident's health care records. Upon the resident's death, the family, the resident's physician and the coroner were notified immediately.

The licensee had failed to ensure that the Director was informed immediately when resident #001 died as a result of a fall.

---

**Issued on this 3rd day of January, 2018**

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

**Original report signed by the inspector.**