Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 8, 2020 | 2020_779641_0033 | 013372-20, 015945-20, 018534-20 | 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): November 30, December 1 and 2, 2020.**

**This inspection was conducted in reference to intake logs #013372-20, CIS #2728-000004-20 and #015945-20, CIS #2728-000006-20 related to residents having fallen sustaining injuries; and intake log #018534-20, CIS #2728-000007-20 related to a resident being missing for less than 3 hours.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Administrator, the Director of Care, the Assistant Director of Care, the Activity Director, the Environment Service Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Activity Aides and residents.**
**During the course of the inspection, the Inspector observed staff to resident interactions and the door locking/ alarming system, reviewed resident health care records, critical incident reports and policies and procedures related to falls prevention and safe and secure doors.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Falls Prevention**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 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 | Légende<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. 9. Doors in a home**

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

**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all doors leading to secure outside areas that preclude exit by a resident were equipped with locks to restrict unsupervised access to those areas by residents.

A resident was noted to be missing from the reception area. The licensee's missing person protocol was initiated, and the resident was found in less than three hours, outside in a secured courtyard off the dining room, having fallen but unharmed. The door's alarming mechanism had been bypassed earlier in the day and had not been reactivated. The door had not been checked at the beginning of the shift as required on the Registered staff checklist, to ensure that the alarm was activated thus allowing unsupervised access to the courtyard by the resident.

Sources: critical incident report; resident's health care record including progress notes; interviews with the Director of Care, Activity Director and other staff. [s. 9. (1) 1.1.]

***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 all doors leading to secure outside areas that preclude exit by a resident are equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.***

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**WN #2: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of a resident being missing for less than three hours and who returned to the home with no injury or adverse change in condition.

A resident was noted to be missing from the reception area. The licensee's missing person protocol was initiated, and the resident was found outside in a secured courtyard, having fallen but unharmed. A critical incident was submitted to the Director 14 business days after the incident occurred.

Sources: critical incident report, interview with the Director of Care. [s. 107. (3)]

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**Issued on this 18th day of December, 2020**

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

**Original report signed by the inspector.**