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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2017	2017_520622_0020	007374-17	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

HEATH HEFFERNAN (622)

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): June 22, 23, 2017

Critical Incident related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses, Personal Support Workers and Physicians.

Also during the course of the inspection the inspector observed resident care and services, reviewed health records and pertinent policy and procedure.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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 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. 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 Licensee has failed to 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):
2. An unexpected or sudden death, including a death resulting from an accident.

The CIS report indicated on a specified date, resident #001 had sustained an injury resulting in an unexpected death.

A review of the homes document titled; Death and Discharge Checklist dated a specified date indicated resident #001's time of death was at a specified time, furthermore the DOC was made aware of the resident's death at a specified time.

A further review of the CIS report indicated the licensee submitted the report of an unexpected death to the Ministry of Health and Long Term Care (MOHLTC) on a specified date and time several hours after the DOC had been notified of resident #001's death.

During two separate interviews, RN #104 indicated the death of resident #001 was considered to be an unexpected death. Critical incidents such as unexpected deaths would be reported to the DOC. RN #104 stated she reported the incident and resident #001's unexpected death by telephone to the DOC on a specified date.

During an interview RN #105 indicated the practice in the event of a critical incident was; the registered staff report immediately to the DOC or ADOC. RN #105 further indicated it was the responsibility of the DOC or ADOC to make the report to the MOHLTC.

During interviews, DOC #100 and ADOC #101 indicated they were aware that incidents of unexpected or accidental deaths were to be reported to the MOHLTC immediately. DOC #100 indicated reporting an unexpected or accidental death to the MOHLTC would be the responsibility of the DOC or ADOC. DOC #100 further indicated she had not recognized resident #001's death as unexpected therefore had not notified the MOHLTC immediately. The DOC indicated that she should have used the MOHLTC after-hours phone line to report the unexpected death of resident #001 immediately however, had not.

The Licensee failed to ensure that the Director was immediately informed of resident #001's unexpected death. [s. 107. (1)]

Issued on this 27th day of June, 2017

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

Original report signed by the inspector.