



**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 rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2017	2017_664602_0024	016651-17, 017066-17	Complaint

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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

**This inspection was conducted on the following date(s): August 11, 30 & 31 and
September 1, 2017**

**016651-17 Complaint/Critical Incident - regarding alleged resident to resident
sexual abuse**

017066-17 Complaint - regarding improper care / harm .

**During the course of the inspection, the inspector(s) spoke with the Acting
Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC),
Registered Nurses (RN), Registered Practical Nurses (RPN), a maintenance staff,
Personal Support Workers (PSW), the Food Services Supervisor, the Registered
Dietician, family members and residents. As part of the inspection, electronic
records & hard copy charts were reviewed, observations of care & service delivery
were made and staff interviews were completed. Additionally, the Home's
investigation documentation and relevant policies and procedures were
considered.**

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

- 1. A change of 5 per cent of body weight, or more, over one month.**
- 2. A change of 7.5 per cent of body weight, or more, over three months.**
- 3. A change of 10 per cent of body weight, or more, over 6 months.**
- 4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

Findings/Faits saillants :

1. The licensee has failed to ensure that weight changes in excess of 5 percent of body weight over a one month period were assessed using an interdisciplinary approach and that actions were taken and outcomes evaluated.

Resident #001 was admitted to Helen Henderson Care Centre on a specified date where s/he presented with significant transitional challenges. The resident was assessed by the home's registered dietitian (RD) on a specified date as at "moderate nutritional risk" given a level of cognitive impairment that could affect food intake. The RD also noted other diagnoses that could increase the resident's nutritional risk.

The resident's weight on admission was documented; further weights and associated warnings were reviewed and included a weight change of -5.0% at less than 1 month and a weight change of -10% at less than 2 months in the home. The home's policy titled "Resident Nourishment" requires that weight loss of 4.1 Kg for residents weighing 68- 80 Kgs or of 5 Kg or more for residents weighing 91 Kg be reported to registered staff. The policy further outlines that registered staff are to complete the "Change in Nutritional Status" to refer the RD to the need for re-assessment of nutritional risk/needs.

The RD confirmed that the normal process at the home, once weights trigger a warning is for the registered staff to complete a paper referral on the nutritional change form which is then inserted into the RD binder alerting the dietitian that an assessment is required. The RD advised that she did not receive a referral. There was no referral found in the electronic record, the hard copy chart or the RD's files. The dietitian further shared that resident's #001 "did not come up on her radar as someone at nutritional risk, despite [the resident's] cognitive status".

An electronic and hard copy chart review, progress notes and interviews with registered and unregistered staff, the FSS and the RD indicate that a "change in nutritional status" form was not completed as per policy. The resident's loss of >10 Kgs over a 2 month period was not assessed; there were no actions taken, or outcomes evaluated as a result of the missed assessment. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]



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Issued on this 20th day of September, 2017

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

Original report signed by the inspector.