Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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
Dec 12, 2019	2019_520622_0028	019637-19	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): December 6, 10, 2019

The following log was completed during this inspection:
Log #019637-19/Critical Incident System report (CIS) #02728-000014-19 related to a fall incident with hospital transfer and significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), the Physiotherapist, a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs)

Also during the course of the inspection, the inspector reviewed the Critical Incident System (CIS) report, electronic and hard copy health records, and observed resident care and services.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #001 that sets out clear directions to staff and others who provide direct care to the resident.

During an interview with inspector #622 on December 10, 2019, Personal Support Worker (PSW)#100 stated that staff would follow the direction for care on the plan of care, the resident information sheet in the resident's closet and the logo above the resident's bed.

During separate observations on December 6, 2019 and December 10, 2019, inspector #622 observed resident #001 walking independently, and at other times they were receiving assistance from staff. Resident #001's bed was also noted to have a personal alarm and a bed alarm on it.

On December 6, 2019, inspector #622 reviewed resident #001's current plan of care dated October 23, 2019 on Point Click Care, which stated that resident #001 was at risk for falls, required supervision, cuing and encouragement during transfers however, for mobility they required the assistance of one staff for transfers and ambulation along with a loaner wheelchair if needed. The plan of care did not indicate that resident #001 required a personal alarm or bed alarm while in bed.

On December 6, 2019, inspector #622 reviewed the Resident Information Sheet in resident #001's closet dated July 22, 2019. The Resident Information Sheet stated that resident #001 did not use a bed alarm, was independent for mobility from sitting to standing, for transfers, walking in their room and outside of their room.

During an interview with inspector #622 on December 10, 2019, Director of Care (DOC) #105 reviewed resident #001's plan of care documentation and the Resident Information Sheet from the resident's closet. DOC #105 stated that since there were discrepancies between the plan of care and the Resident Information Sheet related to mobility, transferring, ambulation and the use of the personal and bed alarms had not been entered on either document, the plan of care was not offering clear direction to the staff who care for resident #001. [s. 6. (1) (c)]

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 that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,, to be implemented voluntarily.

Issued on this 12th day of December, 2019

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

Original report signed by the inspector.