Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 14, 2023	
Inspection Number: 2023-1224-0003	
Inspection Type: Critical Incident System	
Licensee: Gibson Holdings (Ontario) Ltd.	
Long Term Care Home and City: Helen Henderson Nursing Home, Amherstview	
Lead Inspector Carrie Deline (740788)	**Inspector Digital Signature** Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.03.15 11:31:08 -04'00'
Additional Inspector(s) Ashley Bernard-Demers (740787)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 7 - 9, 2023.

The following intake(s) were inspected:

- Intake: #00015891 - CIS 2728-000007-22 Resident to resident alleged abuse.
- Intake: #00018532 - CIS 2728-000001-23 - Fall of resident causing injury.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding abuse of a resident.

Rationale and Summary
A review of the critical incident report noted that the alleged incident of resident to resident abuse occurred on a day in December; however, it was not reported to the Ministry of Long-Term Care immediately.

Interviews with staff confirmed that an incident of resident to resident physical abuse was not immediately reported to the Director.

Failing to immediately report all allegations of resident abuse and neglect to the Director, places residents at risk of harm.

Sources: Critical Incident Report 2728-000007-22, and interview with ADOC #103 [740787]