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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2014	2014_323130_0012	H-00445-14	Complaint

Licensee/Titulaire de permis

HENLEY HOUSE LIMITED
200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9

Long-Term Care Home/Foyer de soins de longue durée

THE HENLEY HOUSE
20 Ernest Street, St. Catharines, ON, L2N-7T2

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

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 22, 23, 24, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff and personal support workers.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A) According to the plan of care, resident #001 sustained falls on three identified dates in 2012, as a result of sliding out of bed. After the third fall, staff identified in the plan of care that placing a bed-pad on top of the resident's bedspread was increasing their risk of falling as the surface was "much more slippery". The resident sustained a fourth fall later in 2012, again as a result of sliding from the bed. It was identified after this fall that the resident had a high-low bed in place, however, the bed was not in the lowest position and the head of the bed was not elevated as per the written plan because the remote control required to lower the bed to the lowest position and raise and lower the head of the bed was not in working order. On an identified date in 2012, it was recorded in the clinical record that the resident's power of attorney (POA) had noted that once again a bed-pad had been placed on-top of the bedspread and not under it, and that the head of the bed was not elevated. Staff documented this was a "staff oversight". Care was not provided to the resident as specified in the plan on these identified dates.[s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) Resident #001 sustained five falls over a four month period in 2012. Staff interviewed confirmed a bed alarm was put in place following the falls, but that the written plan was not updated to include this intervention. [s. 6. (10) (b)]

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 care set out in the plan of care is provided to the resident as specified in the plan, and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all equipment was maintained in a safe condition and in a good state of repair.

A) On an identified date in 2012, resident #001 sustained a fall from bed. The resident had a high-low bed in place but the clinical record confirmed the remote control required to lower the bed to the lowest position and raise the head of the bed was not in working order. The plan of care indicated the resident was a high risk for falls and required the head of the bed to be elevated as the resident struggled to get themself into an upright position without the head of the bed elevated. Staff interviewed confirmed the bed was not in working order on the date the resident sustained the fall on a specified date in 2012. [s. 15. (2) (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 all equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

Issued on this 23rd day of October, 2014

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