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

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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
Mar 29, 2017	2017_553536_0003	005362-17	Resident Quality Inspection

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

CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), KELLY CHUCKRY (611), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 10, 13, 14, 15, 16, 20, 21, 22, 23, 24 and 27, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection.

Critical Incident System Report:

024786-16-related to: Falls Prevention
031910-16-related to: Prevention of Abuse and Neglect

Complaints:
022851-16-related to: Personal Support Services-Care, Reporting and Complaints
027317-16-related to: Personal Support Services-Care, Prevention of Abuse and Neglect, Dignity, Choice and Privacy and Housekeeping
002558-17-related to: Medication Management, Personal Support Services-Care, Prevention of Abuse and Neglect
035303-16-related to: Personal Support Services-Care, Prevention of Abuse and Neglect, Insufficient Staffing, Continence, Reporting and Complaints
005738-17-related to: Continence Care, Personal Support Services, Reporting & Complaints, Personal Support Services and Prevention of Abuse

Inquiries:
025495-16-related to: Responsive Behaviours
032718-16-related to: Responsive Behaviours
004287-17-related to: Medication Management
005334-17-related to: Responsive Behaviours

Follow Ups
030140-16-related to: Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered staff, dietary staff, Food and Nutrition Manager, Life Enrichment Manager, Building Services Manager, Resident Assessment Instrument-Material Data Set (RAI-MDS) Co-Ordinator, Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping, maintenance, reviewed documentation related to bed safety audits, clinical bed assessments, the minutes for meetings, reviewed policies and procedures, reviewed clinical health records, reviewed meeting minutes, investigation notes, staff files, observed the provision of care, medication administration, and meal service.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_247508_0012	536

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with s. 15. (1) (c), that required a long term care home to ensure that there was an organized program of maintenance services.

The home's policy "Bedrails and Bed Safety", policy number: 08-25, revision date: June 2014, indicated that a Primacare Living Solutions (PLS) bed entrapment focus audit will be completed every six months as per the focus audit scheduler and the home's quality program.

In an interview conducted with the Building Environmental Services Manager, and further discussion, it was acknowledged that the home did not conduct these audits in 2016 as outlined in their policy. [s. 8. (1) (a)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with s.49. (1), that required a long term care home to ensure that there was a falls prevention and management program, that at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches, and the use of equipment, supplies, devices and assistive aids.

On an identified date, resident #101 had a fall. As a result of this incident, the resident sustained an injury. In an interview conducted with staff #384, it was acknowledged that staff members lifted resident #101 off the floor after they had fallen. A mechanical lift was not used to transfer this resident off the floor after the fall. A review of the plan of care for resident #101 at the time of the incident indicated, that they required the assistance of staff for transferring.

The home's policy " Falls", policy number: 09-01, revision date: September 2013, indicated that unless the resident is independent, a mechanical lift will be used to lift the resident from the floor. Staff #394, and the Director of Care (DOC), acknowledged that the home's policy titled Falls was not complied with for this resident.

PLEASE NOTE: this non compliance was issued as a result of a Complaint Inspection #022851-16, which was conducted concurrently with the Resident Quality Inspection (RQI). [s. 8. (1) (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 and ensuring that the Falls policy identifying that a mechanical lift will be used to lift the resident from the floor will be complied with (please note: r. 8(1) (a) is a WN not a VPC), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the bed system was evaluated in accordance with evidenced based practices and if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

Health Canada approved two documents identified as "Guidance Documents" and directed that the recommendations in these documents were to be used to assist health care facilities in the assessment of the resident and the resident's bed system when bed rails were used.

These two documents are identified as: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", developed by the Hospital Bed Safety Workgroup, dated April 2003, and "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", based on the US FDA Guidance Document entitled "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment", which was developed by the Hospital Bed Safety Workgroup and adopted by Health Canada in 2006.

Resident #007 was identified to have two bed rails in the raised position on their bed. One rail was a standard commercial rail used on a number of beds in the home and the second rail was not the standard commercial rail used. A review of the Facility Entrapment Inspection Sheet completed on an specified date, identified that the resident's bed passed all zones of entrapment when tested; however, only identified the testing of the standard commercial rail in place on the bed. Documentation in the resident's clinical record indicated that the rail had been placed on the resident's bed on an identified date. Interview with the Building Services Manager and Assistant Director of Care (ADOC) confirmed that the resident's bed system was not evaluated to minimize risk to the resident. [s. 15. (1) (a)]

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 and ensuring that bed rails and bed systems in the home are evaluated to minimize the risk to the residents, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) The plan of care for resident #451 stated they required one staff to provide extensive assistance.

On identified dates, the resident was observed by the inspector ambulating independently with their walker and self-transferring from their chair to a standing position. Staff #329 and #331 acknowledged the resident was independent with many activities of daily living. Registered staff #416 and #454 confirmed the written plan of care was not based on the needs of the resident.

PLEASE NOTE: This non compliance was issued as a result of Complaint inspections #027317-16 and #002558-17, which were conducted concurrently with the Resident Quality Inspection (RQI). [s. 6. (2)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #101 was admitted to the home on an identified date. At that time, this resident was ordered to receive an identified medication. A quarterly medication review was conducted by the pharmacist on a specified date. This medication review included a suggestion to review the need to continue with the identified medication. On an identified date, the medication was discontinued when the three month drug review was completed by the physician. The Substitute Decision Maker (SDM) was not contacted by the home to discuss the pharmacist's suggestions.

In an interview conducted with the ADOC, it was acknowledged that the home did not provide the SDM the opportunity to participate fully in the development and implementation of the plan of care.

PLEASE NOTE: this non compliance was issued as a result of a Complaint inspection #022851-16, which was conducted concurrently with the Resident Quality Inspection (RQI). [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date, resident #101 had a fall. As a result of this incident, the resident sustained an injury. Staff #384 was the only staff member with the resident at the time of the incident. The plan of care for the resident indicated that two staff were to provide assistance with the identified activity of daily living.

An interview conducted with staff #384, and a subsequent interview conducted with the DOC acknowledged that the the care set out in the plan of care was not provided to the resident as specified in the plan.

PLEASE NOTE: this non compliance was issued as a result of a Complaint inspection

#022851-16, which was conducted concurrently with the Resident Quality Inspection (RQI). [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any time when, the resident`s care needs change or care set out in the plan was no longer necessary.

A) A review of resident #021's plan of care contained information related to their continence level. A review of the Minimum Data Set (MDS) assessment records completed on an identified date, regarding continence in the last 14 days, was coded as identified. During interview with staff # 347 they confirmed the residents continence level which was not consistent with the MDS coding..

On an identified date, the RAI-MDS Co-ordinator confirmed that records in the resident's plan of care were not updated and consistent with the MDS assessment and that they had entered information into Care Plan in reverse order by mistake.[632]

B) A review of resident #500's plan of care, contained information related to the residents continence level. Review Minimum Data Set (MDS) assessment records completed on an identified date, regarding the resident's continence in the last 14 days, contained their continence level as specified.

On an identified date, the RAI-MDS Co-ordinator confirmed that records in the resident's plan of care were not updated and consistent with the MDS assessment, when resident's continence changed based on the 14 days observation period records. This was also confirmed by the DOC.

PLEASE NOTE: this non compliance was issued as a result of a Complaint inspection #035303-16, which was conducted concurrently with the Resident Quality Inspection (RQI). [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date and time, registered staff #424 reported to the ADOC staff #451 that when they entered resident #202's room they found the resident in need of personal care. The Inspector confirmed this information with staff #424. Resident #202 when interviewed by the ADOC was unable to recall if any staff had been into their room.

The DOC and the ADOC staff #451 initiated an internal investigation. Personal Support Worker (PSW) staff #453 during interview with the DOC and ADOC, stated she had been into resident #202's room once during their shift, and did routine checks every 30 to 45 minutes on the resident. These interview notes were confirmed by the ADOC staff #451.

The Administrator confirmed when interviewed that during the internal investigation, they had reviewed the home's video surveillance camera. The Administrator confirmed that when they viewed the surveillance camera footage that the resident's door was closed the entire shift and that staff #453 never entered the room their entire shift. The Administrator confirmed that staff #453 was disciplined. Resident #202 was not protected from abuse/neglect when their care needs were not addressed.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection #031910-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 19. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the residents' health conditions, and other special needs.

A) The clinical record for resident #011 revealed they had a history of an identified medical condition that predated their admission. History of this medical condition was identified in the clinical record as a known diagnosis and staff #454 acknowledged this was an identified problem that required intervention since the resident's admission to the home.

On an identified date, staff #454 confirmed there was no written plan of care in place for the monitoring, treatment and prevention of this medical condition and acknowledged there should have been a plan in place for the management of this medical condition.

PLEASE NOTE: This non compliance was issued as a result of Complaint inspection #005738-17, which was conducted concurrently with the Resident Quality Inspection (RQI) [s. 26. (3) 10.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) The MDS Significant Change Assessment completed on two different identified dates for resident #011, revealed information about the resident's worsening continence level.

On a specified date, the RAI Coordinator staff #454 acknowledged there was no continence assessment completed after the change in the resident's continence level was identified. Although a continence assessment was initiated after the change in incontinence was identified, the assessment was incomplete.

Resident #011 was not assessed using a clinically appropriate assessment instrument that was specifically designed for assessment of continence where the condition or circumstances of the resident required.

PLEASE NOTE: This non compliance was issued as a result of Complaint inspection #005738-17, which was conducted concurrently with the Resident Quality Inspection (RQI). [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A) A complaint was received by the Ministry of Health and Long Term Care (MOHLTC)in regards to a verbal complaint submitted to the home, regarding the discontinuation of the medication for resident #101. The complaint logs for the home were reviewed, and a documented record was not kept of this complaint.

Resident #101 was admitted to the home on an identified date. At that time, the resident was ordered to receive a specified medication.A quarterly medication review was conducted by the pharmacist. Thismedication review included a suggestion to review the need to continue with the specified medication. On an identified date, the medication was discontinued when the three month drug review was completed by the physician. The Substitute Decision Maker (SDM) was not contacted by the home to discuss the pharmacist's suggestions.

B) A complaint was received by the Ministry of Health and Long Term Care (MOHLTC)in regards to a verbal complaint submitted to the home, regarding continence management for resident #101. The complaint log for the home was reviewed, and a documented record was not kept for this complaint.

In an interview conducted with the DOC, it was acknowledged that the home did not keep documented records of the above noted complaints.

PLEASE NOTE: this non compliance was issued as a result of a Complaint inspection #022851-16, which was conducted concurrently with the Resident Quality Inspection (RQI). [s. 101. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) A complaint was received in regards to resident #451 stating that the resident was prescribed specified medications once daily. On an identified date, staff #460 administered the resident their prescribed medication scheduled for two identified dates, which resulted in a double dose of their routine once daily medications.

The DOC confirmed that on that identified date, resident #451, was not administered their medications as specified by the prescriber.

PLEASE NOTE: This non compliance was issued as a result of Complaint inspection #027317-16, which was conducted concurrently with the RQI. [s. 131. (2)]

Issued on this 3rd day of April, 2017

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

Original report signed by the inspector.