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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 9, 2018	2017_569508_0015	014111-17, 021054-17	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

ROSEANNE WESTERN (508)

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): December 19, 20, 21, 27, 28, 29, 2017, and January 2, 2018.

The following inquiries were conducted concurrently during this complaint inspection:

Log #007662-17, related to staffing levels
Log #007969-17 and log #009793-17, related to the management of responsive behaviours
Log #013616-17, related to improper care

During the course of the inspection, the inspector toured the facility, observed provision of care, observed meal services, reviewed relevant policies and procedures, resident diet/texture records, the home's internal investigative notes and resident clinical records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOC), the Maintenance Supervisor, the Nursing Unit Clerk, registered staff, Personal Care Providers (PCP), residents and family members.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

On an identified date in 2017, resident #002 was transferred onto the toilet with the

assistance of two staff. A third party was present. The two staff left the resident who was a high risk for falls to sit for an extended period of time with the understanding that the third party would supervise.

During the home's internal investigation regarding a complaint about this incident, it was identified during staff interviews that there was confusion about whether or not staff could leave the resident on the toilet with a third party present.

A review of the resident's current written plan of care for toileting revealed that clear direction had not been provided with respect to the supervision of the resident while being toileted. The plan of care only indicated that the resident required extensive assistance of two staff.

It was confirmed through documentation review and during interview with the ADOC that that the written plan of care for resident #002 did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. 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 an identified date in 2017, resident #002 had an incident while eating their meal in the dining room. Staff witnessed the incident and intervened; however, the resident was transferred to hospital for further assessment

A review of the resident's nutritional plan of care revealed that at the time of this incident, staff were to provide a specific intervention. On an identified date in 2017, chicken and beans were served to the resident at dinner which required staff follow the plan of care.

After a brief hospital visit, the resident returned back to the home but continued to exhibit symptoms. The resident was transferred back to the hospital where the resident underwent a procedure. Hospital records were reviewed and it was confirmed that this procedure alleviated the resident's symptoms.

During an interview with staff #106 who was present during the initial episode, staff #106 could not verify if the specific intervention had been done. A third party who had been visiting that weekend after this incident indicated that they had been told by staff #106 that this specific intervention had not been done.

It was confirmed through documentation and during interview with staff #106 on December 21, 2017, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #002 required extensive assistance of two staff for transfers and toileting. They were also identified as a high risk for falls.

On an identified date in 2017, the resident was assisted onto the toilet with the assistance of two Personal Care Providers (PCP). A third party was present at this time. One PCP left to respond to other call bells and after a few minutes the other PCP left the resident on the toilet as the resident required more time and a third party was present.

When the resident required assistance off the toilet, the call bell was activated and staff had not responded to the call bell for an extensive period of time. The third party had to leave the resident's room to try to locate staff and indicated that the call bell was ringing for approximately 30 minutes or more.

It was concluded by the home that the call bell could not have been ringing for greater than 30 minutes as indicated in a complaint as the call had not been escalated to the RPN's phone; however, during this inspection, the LTC Homes Inspector tested the call bell system and it was confirmed that the system does not activate the RPN's phones at all. Only the PCP's pagers.

The RPN was documenting at the nursing station and did not respond to the call bell until approached by the third party after an extended period of time.

It was confirmed during review of the internal investigative notes and during interview with the RPN on December 21, 2017, that the licensee failed to ensure staff used safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #001 was transferred to hospital on an identified date in 2017, with a third party for a scheduled procedure. Later that evening, the resident returned to the home with the third party who reported to the registered staff on duty that it had been identified in the hospital that the resident had an alteration in skin integrity.

The third party reported that while in hospital the resident had complained of pain in the affected area. Upon assessment it was identified that the affected area was reddened.

A review of the resident's clinical record revealed that the Registered Practical Nurse (RPN) had documented in the progress notes that an assessment had been done; however, the documentation did not provide a description of the identified area. Further review identified that a skin assessment using a clinically appropriate assessment instrument had not been conducted.

Three days later, the resident's Physician documented that they had assessed the resident as it was noted in the home's communication log that the resident had an identified area that was red and swollen. After the Physician assessed the resident a medication intervention was ordered for the resident.

It was confirmed after review of the documentation and during interview with the Director of Care on December 21, 2017, that the resident exhibited altered skin integrity and that the licensee failed to ensure that the resident received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Issued on this 9th day of January, 2018

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

Original report signed by the inspector.