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
Sep 11, 2019	2019_661683_0015	011775-19, 014408-19, 015207-19	Critical Incident System

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

LISA BOS (683), AILEEN GRABA (682), STACEY GUTHRIE (750)

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): August 1, 2, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27 and 28, 2019.

This inspection was completed concurrently with complaint inspection #2019_661683_0014.

The following intakes were completed during this critical incident inspection:

Two logs were related to falls prevention and management
One log was related to the prevention of abuse and neglect and skin and wound

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director(s) of Care (ADOC), the Life Enrichment Manager, the Environmental Services Manager, registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed temperature logs, reviewed the complaints log and observed residents during the provision of care.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 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 has failed to ensure that resident #009 was not neglected by the licensee or staff.

O. Reg. 79/10, s. 5, defines neglect as failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well being of one or more residents.

A CI report was submitted to the Director on an identified date related to the prevention of abuse and neglect and an area of altered skin integrity for resident #009.

A review of the home's investigation notes by Inspector #682 indicated that on an identified date, the resident was assessed, and it was noted that the resident returned to the home with a newly identified concern.

A clinical record review indicated that on three identified dates, Personal Support Worker (PSW) #114 documented that the resident had altered skin integrity in Point of Care (POC) tasks. On an identified date, PSW #113 documented an identified area of altered skin integrity on the 'bath day skin and oral assessment' sheet. Initials of the Registered Practical Nurse (RPN)/Registered Nurse (RN) who should have completed the follow up related to PSW #113's findings were missing.

Further record review indicated that on an identified date, PSW #114 documented an area of altered skin integrity on the 'bath day skin and oral assessment' sheet. The assessment sheet included initials that RPN #110 completed the necessary follow up related to the PSW's findings. A review of the clinical records did not include an assessment, or any follow up by RPN #110 related to the PSW's findings on the identified date.

A review of the home's investigative notes included the following: On an identified date, PSW #114 identified a specific area of altered skin integrity on resident #009 and did not report the finding to registered staff. On an identified date, PSW #117 identified an area of altered skin integrity on resident #009 but did not report it to registered staff. On an identified date, RPN #110 was aware of resident #009's altered skin integrity but they did not complete or document an assessment, or any follow up but reported the finding to oncoming shift nurse, RPN #118. On two identified dates, RPN #110 did not complete or document a skin assessment or follow up but reported the finding to oncoming staff. A head to toe assessment from an identified date indicated that resident #009's altered skin

integrity was assessed and documented by RPN #118.

During an interview with Inspector #682, RPN #110 stated that they were aware that resident #009 had altered skin integrity on the identified area and they did not complete the assessment on their shift, but they reported it to the oncoming shift to complete. RPN #110 also confirmed that the assessment of the resident's area of altered skin integrity was not done until an identified date, several days after it was first identified by PSW staff. During an interview, the Director of Care (DOC) stated that several PSWs noted an identified area of altered skin integrity and it was reported to three registered staff on several occasions. The DOC acknowledged that between the identified dates, registered staff did not assess or complete any follow up related to PSW reports of resident #009's altered skin integrity. The DOC confirmed that resident #009 most likely returned to the home with the underlying altered skin integrity. The DOC confirmed that the home failed to provide care and services related to resident #009's area of altered skin integrity between the identified dates, and that there was a pattern of inaction by both PSW and registered staff. [s. 19. (1)]

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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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 has failed to ensure that when resident #009 exhibited altered skin integrity, including skin breakdown and pressure ulcers, 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.

A CI report was submitted to the Director on an identified date related to the prevention of abuse and neglect and an area of altered skin integrity for resident #009.

A review of the home's investigative notes included documentation that on an identified date, PSW #119 noted an area of altered skin integrity on resident #009, and reported it to registered staff. A review of the clinical records did not include an assessment by registered staff related to the PSW's findings on the identified date. Further record review indicated that on an identified date, PSW #114 documented an area of altered skin integrity on the 'bath day skin and oral assessment' sheet. The assessment sheet included initials that RPN #110 completed the necessary follow up related to the PSW's findings. A review of the clinical records did not include an assessment by registered staff related to the PSW's findings on the identified date. Further clinical review included a head to toe assessment from an identified date, where RPN #118 identified an area of altered skin integrity on resident #009.

A review of the licensee's policy #03-01, titled "Skin Care - Program Overview," last revised on an identified date, indicated the following: "Any concerns are reported to registered staff who are then responsible for further assessing the area, documenting the assessment and completing any follow up required." Additionally, the policy included the following: "Documentation 1. Head to Toe assessment in point click care (PCC)- Used to document what was observed on the skin."

During an interview, RPN #110 stated that they were aware that a PSW had identified an area of altered skin integrity on an identified date; they did not complete the assessment on their shift, but they reported it to the oncoming shift to complete. RPN #110 also confirmed that the assessment of the resident's area of altered skin integrity was not done until an identified date, after it was reported by the PSW. During interviews, RN #116 and the DOC stated that it was expected that staff were to complete the skin assessments and follow up during the same shift an area of altered skin integrity was reported. The DOC confirmed that when resident #009 exhibited an area of altered skin integrity between the identified dates, the resident did not receive 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)]

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 a resident exhibiting altered skin integrity, including skin breakdown and pressure ulcers, 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, to be implemented voluntarily.

WN #3: 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 and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1), and in reference to O. Reg. 79/10, s. 50 (1), the licensee was required to have an organized skin and wound care program that promoted resident comfort and mobility, the prevention of infection, including the monitoring of residents.

Specifically, PSW staff did not comply with the licensee's policy #03-01, titled "Skin Care - Program Overview," last revised on an identified date, which was part of the licensee's skin and wound care program.

The Skin Care policy stated:
"The overall goals of a preventive skin care program are to: prevent and address dryness; replace lost moisture; protect the skin from damage from friction, shear, tears; observe for changes that may require further treatment. Any concerns are reported to registered staff who are then responsible for further assessing the area, documenting the assessment and completing any follow up required."

A CI report was submitted to the Director on an identified date related to the prevention of abuse and neglect and an area of altered skin integrity for resident #009.

A clinical record review indicated that on three identified dates, PSW #114 documented an area of altered skin integrity for resident #009 in POC tasks. On an identified date, PSW #113 documented an area of altered skin integrity on the 'bath day skin and oral

assessment' sheet. Initials of the RPN/RN completing necessary follow up related to PSW #113's findings were missing.

A review of the home's investigative notes included the following: On an identified date, PSW #114 noted an area of altered skin integrity on resident #009 and they did not report the finding to registered staff. On an identified date, PSW #117 noted an area of altered skin integrity on resident #009 but they did not report it to registered staff.

During an interview, PSW #112 stated that they were to report any skin changes to registered staff verbally during the same shift the alteration in skin integrity was identified. During an interview, the DOC confirmed that PSW staff did not report resident #009's altered skin integrity to registered staff as per the licensee's skin care policy and that the policy was not complied with.

This finding will serve as further evidence to support Compliance Order (CO) #001 issued on May 24, 2019, during critical incident inspection #2019_575214_0007 to be complied November 14, 2019. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff received training in skin and wound care.

A CI report was submitted to the Director on an identified date related to an area of altered skin integrity for resident #009.

In an interview with the DOC, they indicated that due to some technical difficulties with their online training system, all direct care staff did not receive training in skin and wound care in 2018.

The home did not ensure that all direct care staff received training in skin and wound care in 2018. [s. 221. (1) 2.]

Issued on this 12th day of September, 2019

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

Original report signed by the inspector.