Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 20, 2021	2021_704682_0004	021192-20, 022219-20, 002161-21	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 Catherines ON L2N 7T2

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

AILEEN GRABA (682), GILLIAN HUNTER (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): March 15, 16, 17, 18, 19, 23, 24, 25, 26, 29, 30, 31, April 1, 6 and 7, 2021.

This inspection was conducted with the following intakes:
021192-20 related to neglect, bathing and continence care
022219-20 related to plan of care and change in condition
002161-21 related to neglect, plan of care, reporting and complaints

The following Critical Incident intakes were conducted concurrently with the Complaint inspection:
002935-20 (2909-000003-20) related to responsive behaviour and prevention of abuse and neglect
016965-20 (2909-000014-20) related to falls
018383-20 (2909-000015-20) related to hospitalization and change in condition
021811-20 (2909-000020-20) related to safe transfer and positioning techniques
022979-20 (2909-000002-20) related to falls
000185-21 (2909-000001-21) related to falls

Please note: Findings of non-compliance related to Long-Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 6 (7) related to plan of care was identified in a concurrent Critical Incident System (CIS) inspection, 2021_704682_0005, and was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Office Manager, Acting Life Enrichment Manager, Behaviour Supports Ontario (BSO) staff, front entrance screeners, housekeeping, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) toured the home, reviewed investigative notes, staffing schedules, resident health records, meeting minutes, program evaluations, policies and procedures, complaints binder/logs, Critical Incident System (CIS) submissions and observed Infection Prevention and Control (IPAC) practices, residents and provision of care.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A review of the Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, and the Ministry of Long Term Care (MLTC) COVID-19 Visiting Policy stated the following:
"A caregiver is a type of essential visitor who is designated by the resident and/or their substitute decision-maker and is visiting to provide direct care to the resident (e.g. supporting feeding, mobility, personal hygiene, cognitive stimulation, communication, meaningful connection, relational continuity and assistance in decision-making).
• A maximum of 2 caregivers may be designated per resident at a time.
• Examples of caregivers include family members who provide meaningful connection, a privately hired caregiver, paid companions and translators."

The Director of Care (DOC) stated they maintained the home's visitor list and a resident had two individuals listed as essential caregivers. In addition to the two individuals listed, the DOC also stated the resident had a support worker. The DOC and the Administrator were not able to define the support worker duties and confirmed that they met the criteria for essential caregiver. Failure to follow the additional precautions outlined in the COVID-19 visitor policy by not limiting and allowing more than two essential visitors for the resident increased risk of potential exposure to COVID-19.

The home was not a safe and secure environment for its residents when staff did not follow the requirements and measures set out in Directive #3 implemented to protect residents in long term care homes from COVID-19.

Sources: Electronic medical record (EMR), Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, The Ministry of Long Term Care (MLTC) Covid -19 Visiting Policy, Interviews with Administrator, DOC, RN, PSW and other staff. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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 failed to ensure that the care set out in the plan of care for a resident was provided as specified in the plan.

A) According to the plan of care, a resident required assistance with activities of daily living (ADLs) and was at risk for falls. The resident had a history of responsive behaviours and a strategy identified in the care plan in response. Progress notes indicated the the resident had two incidents when they exhibited the responsive behaviour and the strategy was not implemented. The care was not provided as specified in the plan.

Sources: Resident's progress notes, care plan, interviews registered staff, PSW's. [s. 6. (7)]

B) A resident was found to have sustained an injury as a result of a fall. The resident required further medical intervention. The resident's plan of care identified cognitive impairment. At the time of the incident, the resident required assistance with ADL's. A Registered Practical Nurse (RPN) stated PSW staff were assisting the resident and that they had reported the resident had a fall. The PSW confirmed that they were not supervising the resident. The DOC stated that at the time of the incident the resident required assistance and supervision. Because the care set out in the plan of care related to supervision and assistance was not provided as specified, the resident had a fall.

Sources: Electronic medical record, Interview with PSW, RPN and the DOC. [s. 6. (7)]

C) According to the plan of care, the resident was at risk for falls. The plan of care included fall prevention strategies. On an identified date, the resident was observed and confirmed they did not have the fall prevention strategies in place.

Sources: Resident's clinical record, observations,and interview with RPN. (130) [s. 6. (7)]

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

According to progress notes, a resident had a change in condition. Progress notes did not include an assessment of the resident. The resident also had a previous change in condition with a recommendation to monitor. No further monitoring or re-assessments were found in the resident's clinical record. Two RN's were interviewed and they identified that they would assess the resident when a resident had a change in condition. The RN identified that the information should be documented in resident's progress notes and that they did not assess the resident. The DOC confirmed there was no evidence that the resident was assessed when they experienced a change in condition. The resident was as risk for clinical deterioration and harm when they were not reassessed and the plan of care was not reviewed and revised when their care needs changed.

Sources: Electronic medical record, Interviews with staff. [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 the care set out in the plan of care is provided to the resident as specified in the plan; to 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 the resident's care needs change or care set out in the plan is no longer necessary, 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 LTCHA S. O. 2007, s. 8 (1) , and in reference to O. Reg. 79/10, s. 17 (1), the licensee was required to have written procedures that included a resident-staff communication and response system.

Specifically, staff did not comply with the licensee's policy titled: "Nurse Call System," which stated:
• "Answer the call bells promptly, If busy and it is not an emergency situation, explain to the resident that you are working with another resident at the moment and that you will return in a few minutes to assist him/her
• Turn off call bell".

Audits of a resident's call bell indicated that in an identified month, staff responsiveness took an identified period of time. The DOC and Administrator confirmed staff were not complying with the home's policy as staff were not turning off call bells when responding as evidenced by the call bell audits. By not promptly responding and turning off resident call bells, the resident's safety was placed at risk.

Sources: resident's call bell audits, Nurse Call System policy, Interviews with Administrator, DOC and other staff [s. 8. (1) (b)]

WN #4: 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

Electronic correspondence (email) was sent by a resident's substitute decision maker (SDM) to the Director of Care (DOC) and Administrator identifying care concerns. On an identified date, a response was made to the SDM via email that identified the home was developing an action plan. The complaint log/binder was reviewed and no documentation was found regarding the nature of the complaint/concerns, any actions taken to resolve the complaint/concerns or any responses provided to the complainant.

The licensee's "Complaints" policy directed the Administrator/Designate to do the following:
• "Provide the author of the complaint with an estimated date of completion for the investigation.
• The written response will include what the home has done to resolve the complaint
• The written complaint will be in entered on the complaint log"

The DOC confirmed that they did not document any actions or responses in the home's complaint log/binder in relation to the resident's SDM emails.

Sources: Emails from resident's SDM, Complaints Policy, complaint binder/log, interview with DOC. [s. 101. (2)]

Issued on this 27th day of April, 2021

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

Original report signed by the inspector.