Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: December 30, 2022	
Inspection Number: 2022-1393-0003	
Inspection Type: Complaint Follow up Critical Incident System (CIS)	
Licensee: Henley House Limited	
Long Term Care Home and City: The Henley House, St Catharines	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2022.12.30 12:00:12 -05'00'
Additional Inspector(s) Lesley Edwards (506)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 14, 16, 19-22, 2022

The following intake(s) were inspected:

- Intake: #00002774, CIS #2909-000036-22 was related to the prevention of abuse and neglect and skin and wound;
- Intake: #00014478 (complaint) was related to skin and wound and Infection Prevention and Control (IPAC); and
- Intake: #00014499, CIS #2909-000108-22 was related to skin and wound and reporting/complaints.
- Intake: #00007358 – Follow-up to CO #001 from inspection #2022_820130_0002 regarding O. Reg. 79/10 s. 33 (1)., CDD June 29, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 33 (1)	2022_820130_0002	001	Lesley Edwards (506)

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Safe and Secure Home

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 5

The licensee has failed to ensure that the long-term care home (LTCH) was a safe and secure environment for its residents.

Rationale and Summary
During a tour of the home, the LTCH Inspector observed several tools outside of a resident's room unattended with residents in the area. Upon speaking with staff, they confirmed that the home had contractors in who were working in the home and confirmed that they should not have left the area unattended with the potentially dangerous items out as there were residents in the area.

After 10 minutes, the LTCH inspector informed the Environmental Service Manager (ESM) who stayed in the area until the contractors returned and removed the potentially dangerous items immediately to the linen closet to ensure that the residents were kept safe and secure.

Sources: Observation of the area; staff interviews.
[506]

Date Remedy Implemented: December 14, 2022

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (a)

A) The licensee has failed to ensure that a resident's plan of care set out the planned care for the resident related to a preventative intervention.

Rationale and Summary
An intervention was observed in place for a resident, as confirmed by a Personal Support Worker (PSW). The resident's clinical record was reviewed and there was no documentation for the use of the intervention.

A Registered Nurse (RN) stated that the intervention was in place as a preventative measure as per family request. They acknowledged the intervention was changed on a regular basis, but that it was not in the resident's plan of care and should have been. The resident's plan of care was updated to reflect the preventative intervention.

Sources: A resident's clinical record; interview with a PSW, RN and other staff.
[683]

Date Remedy Implemented: December 21, 2022

B) The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident related to additional precautions.

Rationale and Summary
A resident had additional precautions signage posted on their door. Their written plan of care was reviewed, and it did not indicate that they required additional precautions, or the related diagnosis.

The Infection Prevention and Control (IPAC) lead acknowledged the resident's plan of care did not include the diagnosis or their need for additional precautions, and the plan of care should have included this direction to staff. The IPAC lead immediately updated the resident's plan of care.

Sources: Observation; review of a resident's plan of care and interview with the IPAC lead.
[506]

Date Remedy Implemented: December 14, 2022

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
A) The IPAC Standard for Long-Term Care homes, indicated under section 9.1 that additional precautions shall include (e) point-of-care signage indicating that enhanced IPAC control measures were in place.

Signage for donning and doffing of Personal Protective Equipment (PPE) was posted on a resident's door and a PPE caddy was also outside of their room.

Their written plan of care indicated they required additional precautions and the Registered Practical Nurse (RPN) acknowledged that the resident required additional precautions and that point-of-care signage had fallen off the door or was removed. The signage was immediately posted back on the resident's door.

Sources: Observations; a resident's clinical record; interview with a RPN and the IPAC lead.
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Date Remedy Implemented: December 14, 2022.

B) The IPAC Standard for Long-Term Care homes, indicated under section 6.1 that the licensee shall make PPE available and accessible to staff and include having a PPE supply ensuring adequate access to PPE for routine and additional precautions.

During a tour of the home, two resident rooms were noted to have point-of-care signage identifying the

need for additional precautions. There was no PPE caddy in place and interview with a PSW confirmed that the residents were on additional precautions and the PPE caddies kept disappearing.

The IPAC lead confirmed that the residents required PPE caddies for routine and additional precautions and to have PPE available and accessible to staff and immediately had staff put the PPE caddies in place.

Sources: Observation of residents rooms; interview with IPAC lead and other staff.
[506]

Date Remedy Implemented: December 14, 2022

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that a resident's plan of care set out the planned care for the resident related to an intervention to support skin integrity.

Rationale and Summary
A resident’s clinical record indicated that they had an area of altered skin integrity. The area was assessed, and a recommendation was made to support healing.

A Personal Support Worker (PSW) reported that due to the resident's area of altered skin integrity, they were given direction regarding care to promote healing and not to aggravate the area. They reported when they arrived at work that day, the direction had not been followed by staff on the previous shift.

A Registered Nurse (RN) confirmed the direction that was provided to staff to promote healing and reduce aggravation. They stated that the home's staff were aware of the intervention, but agency staff sometimes were not.

The resident's written plan of care was reviewed, and there was no direction to staff regarding the specified intervention, as confirmed by the Director of Care (DOC).

There was risk for further skin irritation when the resident's written plan of care did not include

direction regarding the intervention.

Sources: A resident's clinical record; interview with a PSW, RN, the DOC and other staff.
[683]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directives that applied to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that regular IPAC self-audits were conducted in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario.

Rationale and Summary
The Minister's Directive stated that the home was to conduct regular IPAC self-audits following at a minimum the Public Health Ontario (PHO) COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirements Homes, at a minimum every two weeks when the home was not in an outbreak, and at a minimum once a week when in an outbreak.

Record review and interview with the IPAC lead, confirmed that they were aware of the self-audits but confirmed that the audits had not been completed at the frequency that was required in the guidance document when the home was in an outbreak and when the home was not in an outbreak.

The residents were placed at increased risk of COVID-19 transmission when the IPAC lead did not conduct regular IPAC self-audits in accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, using the PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes.

Sources: Interview with IPAC lead; Minister's directives: COVID-19 response measures for long-term care homes dated April 27, 2022, and PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes.

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WRITTEN NOTIFICATION: General Requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the skin and wound care and the pain management programs were evaluated and updated at least annually in accordance with evidence-based practices.

Rationale and Summary
At the time of the inspection, the home was unable to produce evidence that their skin and wound and pain management programs were evaluated and updated in accordance with evidence-based practices.

An Associate Director of Care (ADOC) acknowledged that they were unable to locate any program evaluations for the skin and wound program and the pain management program.

There was risk that necessary improvements to the home's skin and wound and pain management programs would not be made when the home failed to evaluate the programs annually.

Sources: Records not available; interview with an ADOC
[683]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident’s area of altered skin integrity was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
An area of altered skin integrity was observed on a resident, as confirmed by a PSW. The resident's clinical record was reviewed and there was no documentation of any assessments completed for the area.

An ADOC acknowledged that an initial skin assessment was not completed for the area of altered skin integrity, and should have been.

There was risk that appropriate treatment interventions may not be initiated when the resident's altered skin integrity was not assessed using a clinically appropriate assessment instrument.

Sources: Resident observations; a resident's clinical record; interview with a PSW, an ADOC and other staff.
[683]

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A) A resident's clinical record indicated that they had an area of altered skin integrity. According to their electronic Treatment Administration Record (eTAR), weekly wound assessments were scheduled to be completed for wound monitoring.

The resident's clinical record was reviewed for a period of approximately five months. Registered staff signed off on the eTAR that the weekly assessments were done for the resident on 10 occasions, but there was no documentation of an assessment completed. On two additional occasions, staff documented reasons for not completing the weekly assessments, and on one occasion there was no documentation of the assessment, nor why it was not completed.

Of the skin assessments that were completed for the resident, the size of the wound was not measured on five of the seven completed assessments.

The DOC acknowledged that it was clinically indicated to assess the resident's wound weekly and that there was no documentation that the above noted assessments were completed. They also acknowledged that staff were required to measure the size of the wound on the weekly skin assessments, and that it was not consistently completed.

There was a risk that deterioration of the resident's altered skin integrity would not be identified as it

was not assessed on a weekly basis.

B) A review of a resident's eTAR indicated that there was an order for a dressing for an area of altered skin integrity. Staff documented that the care was provided since the date the dressing was ordered.

Two RNs stated that separate skin assessments were completed for residents who had multiple areas of altered skin integrity.

The resident's eTAR was reviewed and there was no order for a weekly skin assessment for the area of altered skin integrity, nor any documentation of weekly skin assessments completed.

An ADOC acknowledged weekly skin assessments were not completed on the resident's area of altered skin integrity and they should have been.

There was a risk that deterioration of the resident's altered skin integrity would not be identified as it was not assessed on a weekly basis.

Sources: A resident's clinical record; interview with RNs, an ADOC and the DOC.
[683]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that there was a documented record kept in the home that included the nature of each written complaint that was received.

Rationale and Summary
A complaint was submitted to the Executive Director (ED) regarding concerns related to the care of a resident.

The home's Quality Process Consultant acknowledged that the home's complaint log had not been completed for several months, and therefore the complaint was not entered in the log.

Failure to maintain a record of the complaints as required increased the potential for additional

complaints and inconsistent actions to resolve concerns.

Sources: CIS #2909-000108-22; e-mail records; complaints log; interview with the Quality Process Consultant and other staff.
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