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

Hamilton District
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Original Public Report

Report Issue Date: December 1, 2023	
Inspection Number: 2023-1393-0007	
Inspection Type: Complaint Critical Incident	
Licensee: Henley House Limited	
Long Term Care Home and City: The Henley House, St Catharines	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature** Emily C Robins Digitally signed by Emily C Robins Date: 2023.12.14 13:52:24 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 17-18, 20, 23-27, 30, 2023 and November 1-3, 2023.

The following intakes were inspected:

- Intake #00096185 - Complainant with concerns regarding resident care and support services.
- Intake #00097856 - Complainant with concerns regarding food, nutrition, and hydration.
- Intake #00100361 – Critical Incident related to prevention of abuse and neglect.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the plan of care for a resident was revised when their care needs changed.

Rationale and Summary

A resident had a demonstrated history specified health issues. The Pharmacy consultant suggested that an additional dose of a medication be added to the resident's drug regime to assist with these. The Physician reviewed and approved this suggestion, however, an order was not written and the medication was not initiated.

Failure to respond to the needs of this resident by ensuring that the plan of care was revised when their care needs changed may have placed the resident and their fellow residents at risk of harm.

Sources: Progress notes, pharmacy consultation notes, order sheets, electronic Medication Administration Record and interviews with staff [741074].

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 (1) (c) of the Ontario Regulation 246/22 defines physical abuse as: the use of physical force by a resident that causes physical injury to another resident ("mauvais traitements d'ordre physique").

Rationale and Summary

On a specified date, a resident used physical force on another resident that resulted in a mild physical injury to that resident. Staff were able to redirect the aggressor.

Failure to protect a resident from physical abuse by another resident caused actual harm to a resident when they sustained a mild physical injury.

Sources: Critical Incident Report, progress notes, head to toe and pain assessments, and interviews with staff [741074].

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.

The licensee failed to ensure that the following was developed to meet the needs of a resident with responsive behaviours: written approaches to care, including identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Rationale and Summary

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that the home had a responsive behaviours program, and that this program was complied with.

Specifically, staff did not comply with the home's Responsive Behaviours policy, which indicated that for each resident displaying responsive behaviours, a resident focused care plan was to be developed and maintained that included:

- Triggers to the behaviour
- Preventative measures to minimize the risk of the behaviour developing or escalating and;
- Resident specific interventions to address behaviours.

A resident demonstrated on-going responsive behaviours from the time of their admission to the time of the inspection.

Review of the resident’s progress notes and interviews with staff indicated that additional behavioural triggers and interventions to manage these were known about the resident however, they were not included in the care plan.

ADOC #117 indicated that it is important for the resident’s care plan to include the items identified above to ensure direct care staff are aware of behavioural triggers and interventions for the resident to reduce the incidence and severity of these.

Failure to ensure that written approaches to care were developed for the resident, including identification of behavioural triggers that may result in responsive behaviours, put the resident and others at risk of harm.

Sources: Policy: Responsive Behaviours last revised September 2013, progress notes, physical and electronic care plans, interviews with staff [741074].

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee failed to ensure that the organized program of nutritional care and dietary services included the implementation of interventions to mitigate and manage the risk of aspiration for a resident.

Rationale and Summary

A resident's plan of care indicated that they were to receive a specific diet consistency, receive total assistance with feeding from one staff member, and specified safe feeding guidelines.

On a specified date during the inspection, Inspector #741074 observed this resident to be feeding themselves soup that was thinner than the specified diet consistency.

The Dietary Aide serving the meal indicated it is the responsibility of the Personal Support Worker (PSW) serving the resident their soup to thicken it to the required consistency. The Acting Nutrition Manager (NM) clarified that it is the responsibility of the dietary aide.

Dietary staff were re-educated on this process while the inspector was on-site.

Failure to ensure that this resident received the correct diet consistency and was assisted at their meal put them at risk for aspiration and its associated complications.

Sources: Diet order and care plan, observations of resident, and interviews with staff [741074].

WRITTEN NOTIFICATION: Retention of resident records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 276 (1)

The licensee failed to ensure that the record of former resident was retained by the licensee for at least 10 years after the resident was discharged from the home.

Rationale and Summary

Inspector #741074 reviewed a resident's archived paper chart during the course of this inspection and was unable to find their physical care plan. Inspector #741074 also verified that it was not left in the care plan binder on the resident's old home area.

DOC #101 indicated that the physical care plans are archived with the rest of the physical chart and was unable to produce this resident's physical care plan. DOC #114 indicated that the physical care plan was missing but verified that it was present when the resident was living in the home.

Failure to ensure that the resident's physical care plan was retained by the licensee for at least 10 years after the resident was discharged from the home diminished the home's accountability with compliance standards.

Sources: Review of resident's physical chart, observations of resident care plan binder, and interviews with staff [741074].