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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 16, 2024

Inspection Number: 2024-1393-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Henley House Limited

Long Term Care Home and City: The Henley House, St Catharines

Lead Inspector	**Inspector Digital Signature**
Emily Robins (741074)	Emily C Robins Digitally signed by Emily C Robins Date: 2024.07.30 12:44:07 -04'00'

Additional Inspector(s)
Nishy Francis (740873)
Tracey Delisle (741863)
Emily Sweetman (000844)
Jagmail Brar (000845)
Carla Meyer (740860) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 10-14, 17-21, and 24-26, 2024.

The following intakes were inspected:

- Intake #00107957 [Critical Incident (CI) #2909-000019-24] Related to Resident Care and Support Services.
- Intakes #00111108 [CI #2909-000045-24], #00111827 [CI #2909-000047-24], #00111835 [CI #2909-000049-24], #00113057 [CI #2909-000063-24],

#00113486 [CI #2909-000064-24], and #00115410 [CI #2909-000070-24] Related to Prevention of Abuse and Neglect.
- Intake #00113002 - Complainant with concerns regarding Resident Care and Support Services, Food, Nutrition and Hydration, and Continence Care.
- Intake: #00113038 [CI #2909-000060-24] Related to Resident Care and Support Services.
- Intake: #00114234 [CI #2909-000067-24] Related to Resident Care and Support Services.
- Intake: #00115718 [CI #2909-000071-24] Related to Falls Prevention and Management.

The following intakes were completed with this inspection: Intakes #00114682 [CI #2909-000068-24] and #00115012 [CI #2909-000069-24] related to Falls Prevention and Management.

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

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

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)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary

A resident's plan of care specified that the foot pedals on their wheelchair were to be kept in specified positions at specified times.

On a specified date, Inspector #741074 observed the resident self-propelling down the hallway in their wheelchair. Their footrests were not in the position specified in their plan of care. Inspector alerted a staff person who was familiar with the resident. The non-compliance was remedied.

Sources: Observation of resident, resident's plan of care, and interviews with staff [741074].

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that a resident's written plan of care set out the planned care for the resident.

Rationale and Summary

A resident was admitted to the home on a specified date with a medical device. A few months later, the resident complained of pain related to the medical device. Staff identified that the medical device was not serviced as it should be. During the resident's admission process, directions to service the medical device at a specified frequency were not included in the resident's electronic treatment administration record (eTAR) or anywhere else in the resident's written plan of care by the admitting staff person.

There was a potential risk to the resident when the medical device was not serviced as required to maintain the health and wellbeing of the resident.

Sources: Record review of resident's clinical record, interviews with staff [740873]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 3.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language.

The licensee failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Communication abilities, including hearing and language.

Rationale and Summary

A resident's written plan of care did not specify that the resident had two medical conditions that caused intermittent hearing impairment. The resident's plan of care also did not include an intervention to address this where it was required.

Failure to ensure that the resident's plan of care was based on interdisciplinary assessment of the resident's communication abilities including hearing put the resident at risk of impaired hearing and discomfort.

Sources: Resident's plan of care and interviews with staff [741074].

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a staff person used safe positioning devices and techniques when assisting a resident down the hallway in their wheelchair.

Rationale and Summary

On a specified date, Inspector #741074 observed a staff person assist a resident to the dining room in their wheelchair. The resident did not have their foot rests positioned in a way that would allow them to place their feet on the foot rests while being ported.

Failure to ensure that the staff person used the resident's foot rests to ensure safe positioning while porting them to the dining room in their wheelchair placed the resident at risk of injury.

Sources: Observation of resident, the home's policy titled "Wheelchairs and Portering of Residents", and interviews with staff [741074].

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (a)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(a) provide for screening protocols; and

The licensee failed to ensure that the fall program screening protocols were implemented by the registered staff. Specifically, the registered staff failed to complete the quarterly fall assessment for a resident.

Rationale and Summary

According to Ontario Regulations 246/22, s. 11 (1) (b), where the Act or the Regulation requires the licensee of a long-term care home to have, institute or

otherwise put in place any program, the licensee is required to ensure that the program is complied with.

The home's policy titled, "Fall Prevention and Management Program" last reviewed on March 2024 stated that in the case of a resident fall, the nurse will conduct a comprehensive falls assessment when a resident returns back from the hospital, when there is a significant change in health status or on a quarterly basis.

On a specified date, a resident fell and was transferred to the hospital for further treatment and evaluation where they were diagnosed with an injury. On return from the hospital with a significant change in their health status, a comprehensive fall assessment was initiated however was not completed for the resident by the registered staff which did not trigger the resident's fall risk status to be updated.

The resident had another fall incident after this. They were again transferred to the hospital, where they were diagnosed with another injury.

Staff acknowledged that by not completing the fall assessment when the resident returned from the hospital, their falls care plan was not triggered, which would have changed resident's fall risk status and the associated fall interventions.

By not completing the comprehensive falls assessment as per the home's "Falls Prevention and Management Program" the risk of falls for the resident may not have been properly mitigated.

Sources: Interviews with staff, review of home's policy titled "Fall Prevention and Management Program" – last revised March 2024 and review of resident's clinical records [000845].

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and intervention to promote the healing of their wound.

Rationale and Summary

On a specified date, a resident's physician wrote an order for the resident to be seen by a specialist for a wound. The order was not reviewed by the home's registered staff in a timely manner.

By not processing the referral in a timely manner, the resident was placed at risk for impaired wound healing.

Sources: Physician's Order; fax confirmation form; resident's progress notes; and interviews with staff [000844].

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that a resident, who required assistance from one staff person for eating and drinking, was served their meal until someone was available to provide the assistance required by the resident.

Rationale and Summary

On a specified date, Inspector #741074 observed that the resident was served food and drinks at lunch. No one sat down to assist the resident and shortly after the resident spilled their drink on their food and the table.

On another day, Inspector #741074 observed that the resident was again served their food and drinks without assistance from staff to eat. The resident was unable to finish their meal on their own and it was thrown away.

Failure to ensure that resident was not served their lunch until someone was available to provide the assistance required by the resident increased their risk of poor nutritional intake and its associated complications.

Sources: Resident's plan of care, observations of resident and interviews with staff [741074].

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Review, revise and implement interventions that ensure two residents do not sexually abuse any residents.
2. Perform an audit of these residents for 4 weeks to ensure the interventions implemented are effective and no further incidents of sexual abuse occur.

Grounds

A) The licensee failed to protect two residents from sexual abuse by a resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

On a specified date, a resident was wandering in the hallway during night shift. They went into another resident's room and laid down on their bed and started being affectionate and inappropriately touching them, which was found to be non-consensual.

Later, staff found the same resident who had sexually abused the aforementioned

resident in another resident's room and the same behaviour was noted as above. This resident had a diagnosis of Alzheimer's Disease and according to the clinical records was deemed unable to provide consent.

One-to-one supervision was implemented after second incident.

Failure to protect these two residents from sexual abuse by this other resident, put residents at risk for non-consensual sexual abuse.

Sources: Resident's clinical records, Critical Incident Report, interviews with staff, Zero Abuse and Neglect Policy, Home's internal investigation notes. [741863]

B) The licensee failed to protect a resident from sexual abuse by another resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines “sexual abuse” as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

On a specified date, a resident touched another resident without consent.

No new interventions were implemented for the resident who sexually abused the other resident to mitigate the risk of recurrence, putting the resident at risk for sexual abuse.

Sources: Resident's clinical records, Critical Incident Report, interviews with staff, Zero Abuse and Neglect Policy, and Home's internal investigation notes [741863].

This order must be complied with by July 26, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.