Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 31, June 5+6, 2012	2012_072120_0050	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. Catharines, ON, L2N-7T2

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

BERNADETTE SUSNIK (120), CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care and an identified resident. (H-000766-12 & H-000944-12)

During the course of the inspection, the inspector(s) reviewed resident clinical records, the home's policies and procedures on resident's rights, diabetes & glucose management, employee statements and records and the home's investigative documents.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c.8, s. 3(1)1.] The licensee of a long-term care home did not ensure that the following rights of residents were fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

(a) In 2012, a staff member had an interaction with a resident, who was not injured by the contact, but became offended and disrespected by the action. According to both the resident and the staff member, various interactions were exchanged in the past in the name of fun. The resident had never voiced their concerns in the past to staff in the home regarding their disapproval. After the incident, the resident voiced their concerns. When the concern was brought forward to the management of the home, follow-up action was taken. The staff member reported that they were not aware that the interactions were upsetting to the resident.

(b) In 2012, an identified resident reported to a staff member that another staff member was treating them without dignity or respect by an action of the employee. The action ceased for a short time period when the resident first complained, but the action recommenced. The resident voiced their concerns about the action. The management staff conducted an investigation and follow-up action was taken.

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 subsections:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. [LTCHA 2007, S.O. 2007, s.6(8)] The licensee did not ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

In 2012, an identified resident had an elevated blood glucose level. A Registered Practical Nurse (RPN) did not make themselves aware of the contents of the resident's plan of care and requested that the resident drink water to assist in lowering their blood glucose level. The resident refused as the direction was not consistent with their plan of care.

2. [LTCHA 2007, S.O. 2007, s.6(9)1] The licensee did not ensure that the provision of care as set out in the plan of care was documented.

(a) An identified resident had a physician's order for their blood glucose to be taken four times a day and that Humilin R insulin be administered. On a particular date in 2012, insulin was to be administered at 1200 hours and at 1600 hours. The Medication Administration Record (MAR) did not have signatures indicating that the insulin had been administered for either 1200 or 1600 hours.

In 2012, a physician's order for an identified resident required that insulin be administered at 0800 hours and 1200 hours, however neither were signed for on the MAR as being administered. These omissions were confirmed by registered staff as well as the Director of Care (DOC). The resident's results from the 2000 hours glucose test were inconsistently recorded. One value was recorded in the resident's progress notes and a different value recorded on the home's software program called Point Click Care (PCC). It was confirmed by the Director of Care (DOC) that values should be recorded in PCC.

(b) An identified resident had a physician's order for their blood glucose to be tested twice daily on Mondays. The 0800 hours testing on a particular date in 2012 was not documented in the MAR and the value was not recorded in PCC. The physician's order for insulin was not signed for on the particular date in 2012 at 2100 hours on the MAR as confirmed by the DOC.

(c) An identified resident had a physician's order for their blood glucose to be tested twice daily and twice weekly. On a particular date in 2012, it was not signed as being taken at 1700 hours on the MAR as confirmed by the DOC.

Discussion with facility staff confirmed that the omissions on the MAR were documentation omissions only and the medication or treatments had been administered.

Issued on this 26th **day of** July, **2012**

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

B. Smith