Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 11, 2013	2013_240506_0005	H-000827-13	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

LESLEY EDWARDS (506)

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): December 4, 5 and 6, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC),Registered Nurse(RN),Registered Practical Nurse(RPN) Personal Support Workers(PSW),Family member.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided to the resident and reviewed policies and procedures and clinical records.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Personal Support Services

Reporting and Complaints

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.
A) In reviewing the document that the home refers to as the care plan it indicates that resident # 001 is to receive specialized care two times per shift and more frequently as needed. In the resident's electronic medication system (eMAR) it reads that specialized care is to be completed once per shift. The Director of Care confirmed that care was not completed two times per shift as it was not in the eMAR system for staff to document completion.
B) There was a physician's order for treatment to resident # 001 and to assess the need for specialized treatments every shift. This physician's order was not on the resident's eMAR system. The DOC confirmed that this should be on the residents eMAR system to ensure the physician's order was being followed as there was no documentation to confirm this treatment had been completed. There was documentation in the progress notes that indicated resident # 001 was experiencing difficulties with their specialized equipment . [s. 6. (4) (a)]

2. The care set out in the plan of care was not provided to the resident as specified in the plan.
A) In reviewing resident # 001 plan of care it was noted that on 19 separate occasions during the months of October and November 2013 that the resident did not receive specialized care as indicated on the resident eMAR system and no documentation in the resident's progress notes to indicate this care was provided. This was confirmed by the DOC.
B) During an observation on an identified date in December 2013, resident # 001 was noted that they were not receiving the correct dose of a treatment. It was observed that resident # 001 was receiving incorrect dose of treatment as confirmed by physician's order. The RN confirmed that it was the incorrect dose being administered to the resident.
C) In reviewing the document the home refers to as the care plan for resident # 001 it indicates that the equipment is to be checked daily on each shift to ensure that it is working. The checklist that is to be signed off by the registered staff every shift is in the resident's room. In reviewing this checklist for the months of September, October and November 2013 there were 25 days that documentation was not completed to indicate that the equipment had been checked. The RN confirmed that the staff did not complete this checklist required. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 License did not ensure the policy and procedures in the home were being followed and complied with.
A) In the home's clinical procedures manual policy emergency tracheostomy kit (policy number 04-26) indicates that the home should have an emergency tracheostomy kit. During an interview with the DOC she confirmed that the home does not have an emergency kit and was not aware of this policy.
B) In reviewing the policy and procedure for enteral feeding (policy number 06-01), it indicates what care plans are to include, when the tube is to be changed, what to do if the tube accidentally becomes dislodged, frequency of feeding and residual checks and parameters, the size of the syringe to use for flushing and stoma care and the frequency to which this was to be completed. The DOC confirmed that the policy is not being complied with.
C) The policy enterral feeding (policy number 06-01)also indicates that the enteral feeding intake report must be completed every shift and 24 hour summary done. The DOC was not aware of this and confirmed this was not being completed. [s. 8. (1)]

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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The Licensee has failed to provide training and education on two specialized treatments. When interviewing a registered staff member they indicated that there has been no formalized training on specialized treatments. The registered staff did confirm that there was some bed side training on one of the specialized treatments for staff that were working on the day the training was provided. The staff member informed the inspector that multiple staff were uncomfortable with these treatments and have asked for more training. During an interview with registered staff members # 2 and # 3, they also confirmed that there had not been any education regarding either specialized treatments. Staff member # 2 indicated that there was bed side training and this staff member was comfortable with one of the specialized treatments. Staff member # 3 confirmed that they were not comfortable with providing one of the specialized treatments. When speaking with the DOC she confirmed that there has not been any formalized training in the home for specialized treatments and was unable to provide a copy of any training records. The DOC did confirm that there was bed side training by a Nurse Practioner on one of the specialized treatments for staff working that day and there was no record kept of who attended the training. The DOC confirmed that any staff that have been hired within the last year have not been provided the training. [s. 76. (2) 10.]

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 be implemented voluntarily.

Issued on this 18th day of December, 2013

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2013_240506_0005
Log No. / Registre no:	H-000827-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 11, 2013
Licensee / Titulaire de permis :	HENLEY HOUSE LIMITED 200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	THE HENLEY HOUSE 20 Ernest Street, St. Catharines, ON, L2N-7T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOHN BERGIN

To HENLEY HOUSE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan that ensures that staff involved in different aspects of residents care collaborate with each other to ensure the plan of care is consistent and complement each other.

The plan shall be submitted electronically to Lesley Edwards at Lesley.Edwards@ontario.ca by December 31, 2013.

Grounds / Motifs :

1. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A) In reviewing the document that the home refers to as the care plan it indicates that resident # 001 is to receive specialized care two times per shift and more frequently as needed. In the resident's electronic medication system (eMAR) it reads that specialized care is to be completed once per shift. The Director of Care confirmed that care was not completed two times per shift as it was not in the eMAR system for staff to document completion.
B) There was a physician's order for treatment to resident # 001 and to assess the need for specialized treatments every shift. This physician's order was not on the resident's eMAR system. The DOC confirmed that this should be on the residents eMAR system to ensure the physician's order was being followed as there was no documentation to confirm this treatment had been completed. There was documentation in the progress notes that indicated resident # 001 was experiencing difficulties with their specialized equipment . [s. 6. (4) (a)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures that staff provide care for resident # 001 as specified in the plan.

The plan shall be submitted electronically to Lesley Edwards at Lesley.Edwards@ontario.ca by December 31, 2013.

Grounds / Motifs :

1. 1. The care set out in the plan of care was not provided to the resident as specified in the plan.

A) In reviewing resident # 001 plan of care it was noted that on 19 separate occasions during the months of October and November 2013 that the resident did not receive specialized care as indicated on the resident eMAR system and no documentation in the resident's progress notes to indicate this care was provided. This was confirmed by the DOC.
B) During an observation on an identified date in December 2013, resident # 001 was noted that they were not receiving the correct dose of a treatment. It was observed that resident # 001 was receiving incorrect dose of treatment as confirmed by physician's order. The RN confirmed that it was the incorrect dose being administered to the resident.
C) In reviewing the document the home refers to as the care plan for resident # 001 it indicates that the equipment is to be checked daily on each shift to ensure that it is working. The checklist that is to be signed off by the registered staff every shift is in the resident's room. In reviewing this checklist for the months of September, October and November 2013 there were 25 days that documentation was not completed to indicate that the equipment had been checked. The RN confirmed that the staff did not complete this checklist required. [s. 6. (7)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of December, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lesley Edwards

Service Area Office /
Bureau régional de services : Hamilton Service Area Office