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

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

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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
Feb 4, 2014	2014_267528_0002	H-000840-13	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

CYNTHIA DITOMASSO (528), LISA VINK (168)

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): January 16, 17, 20, 21, 22 and 31, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC) and Assistant Director of Care (ADOC), former Director of Care (DOC), Physician, Social Services Worker (SSW), Food Service Manager, Maintenance Supervisor and staff, Nursing Rehab/Restore staff, registered staff, personal support workers, families and residents, related to logs H-000840-13, H-000023-14, H-000721-13, H-000712-13,and H-000762-13.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

a) In August 2013, resident #003 sustained an injury after falling. As a result of the fall, an interdisciplinary post falls meeting was held and three new fall prevention interventions were recommended. Reviewed that plan of care which was revised to include only two of the three interventions. Registered staff confirmed that the written plan of care was not updated to include all fall prevention interventions.

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 ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

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 licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in plan was in compliance with and was implemented in accordance with all applicable requirements under the Act, and was complied with.

A. In January 2014 resident #002 had an unwitnessed fall resulting in a wound. Registered staff initially assessed, cleaned, and dressed the wound. As outlined in the Falls Policy 09-01: "If the resident remains in the home after a fall, registered staff are responsible for ongoing assessment of the resident for 72 hours after the fall. Each shift the resident is to be assessed for i) pain ii) bruising iii) changes in functional status iv) changes in mental status v) changes in range of motion. All assessments and actions during the 72 hour post fall follow-up are to be documented in the progress notes." Reviewed the progress notes for resident #002, specifically post falls documentation by registered staff. It was noted that post fall shift assessments were not documented on two shifts. Registered staff confirmed that the post falls shift assessments were not completed on two shifts during the 72 hours post fall. [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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in plan is in compliance with and is implemented in accordance with all applicable requirements under the Act, and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure all food and fluids were served at a temperature that was palatable to the resident.

A. According to progress notes resident #013 was served luke warm coffee at the breakfast meal in December 2013, while eating in bed independently, due to a recent incident where coffee was spilled. Interview with the front line staff confirmed the change in practice to offer luke warm coffee, instead of hot and cold cereal rather than hot oatmeal, as a safety precaution for the resident. The resident identified that they did not like luke warm coffee, it was not palatable and as a result they were no longer requesting the beverage at meal times. [s. 73. (1) 6.]

2. The licensee did not ensure that all residents were provided with any eating aids, assistive devices, personal assistance or encouragement required to safely eat and drink as comfortably and independently as possible.

A. Resident #013 consumed their meals in their bed room, by choice. In December 2013, the resident spilled hot coffee while eating breakfast, unsupervised, according to the progress notes. Progress noted in December 2013, indicated that luke warm coffee was served at the breakfast meal to avoid the risk of burns, while eating alone in the room, and that the resident was checked 20 minutes after receipt of the meal and was found sleeping without consuming their meal. In January 2014, the resident was found asleep in bed, after consuming half of their meal with food in their hand. Staff identified that checks were provided during the meal to rouse the resident who was noted to be sleeping. The risk of choking was identified. Interviews with front line staff confirmed that the resident was not consistently awake or alert at meal times and that the level of supervision/assistance provided was to "check in" on them while eating. The resident was observed on two occasions during the inspection to be asleep with a partially full meal tray in front of them and no staff in attendance. The resident was not provided with necessary personal assistance required to safety eat and drink as comfortably and independantly as possible. [s. 73. (1) 9.]

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 ensure that all residents are provided with any eating aids, assistive devices, personal assistance or encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with by providing a response to the person who made the complaint, indicating what was done to resolve the complaint, or the reasons the licensee believed the complaint was unfounded.

A. According to the progress notes the Power of Attorney (POA) for resident #013 telephoned the home in November 2013, and voiced concerns regarding the provision of care. The POA communicated concerns, as relayed by the resident, of a staff member being rude which made the resident cry. Interview with the Administrator and previous DOC confirmed that the concerns were fully investigated by the home when reported. The Administrator nor the previous DOC was able to confirm that the POA was notified of the outcome of the internal investigation. Interview with the POA identified that they had no recollection of a response by the home for their identified concerns.
B. The POA of resident #015 sent an email to the ADOC and SSW in December 2013, requesting information regarding the resident and indicating concerns regarding specific care being provided. Interview with the Administrator identified that there was no information located to confirm that the POA was provided a response to all of the concerns communicated in the email. A second email was forwarded to the home in December 2013, by the POA which identified that no response was received from initial communication, this second request was responded to in January 2014, by the ADOC. [s. 101. (1) 3.]

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 ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with by providing a response to the person who made the complaint, indicating what was done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

Findings/Faits saillants :

1. The licensee did not ensure that, before a resident was discharged, notice of the discharge was given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct, (a) as far in advance as possible; or (b) if the circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge.

A. In September 2013, resident #004 had multiple episodes of unmanageable responsive behaviours and was transferred to hospital for assessment. The resident's substitute decision-maker (SDM) was notified of a hospital transfer on the same day. A physicians order for resident discharge was written in September 2013, which the resident was in the hospital. In reviewing the progress notes, it was noted that the hospital was notified of the resident discharge one day before the SDM was notified. [s. 148. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that the resident's record was kept up to date at all times.

The plan of care for resident #015 identified two staff were to provide extensive assistance with bed mobility and for transfers. Staff interviewed reported that consistently two staff were used to provide the assistance to the resident, according to the plan of care. A review of Point of Care (POC) records identified that staff were inconsistent with the level of assistance recorded as provided to the resident ranging between one and two staff members. Staff confirmed that the documentation was not consistently reflective of the actual care provided and the record was not up to date to reflect the provision of care. [s. 231. (a)]

Issued on this 25th day of February, 2014

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