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
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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
Mar 7, 2014	2014_243504_0006	L-000064-14	Complaint

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9

Long-Term Care Home/Foyer de soins de longue durée

Henley Place
1961 Cedarhollow Boulevard, LONDON, ON, N5X-0K2

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

DEIRDRE BOYLE (504)

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 21, 2014.

During the course of the inspection, the inspector(s) spoke with the Resident's Power of Attorney and one other Resident family member, The Administrator, the Director of Clinical Services, the Acting Director of Care, the Pharmacy Technician, the Pharmacist, and two Registered Practical Nurses.

During the course of the inspection, the inspector(s) made observations and reviewed:
the plan of care and progress notes for one Resident, the Medication Administration Records for three Residents, the Home's Medication Management policies and procedures, staff education policies, Falls Prevention policies, the Home's Complaint Policy and other relevant documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

Findings of Non-Compliance were found during this inspection.

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 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 :

The Home's Medication Pass Policy 3-6-1 Revised November, 2013 (p.2/3) requires the Registered staff to administer all of the required medications to the Resident and to stay with the Resident while the Resident takes that medication. Two pills were found at the bedside of Resident #001 in January, 2014 by the Resident's Power of Attorney. This was confirmed by the Registered Practical Nurse and the Acting Director of Care.

1. A review of the electronic medication administration records for Resident #001 revealed that all medications were signed for as having been given to Resident #001 and the Resident's roommate by Registered staff up to and including January 20th, 2014 although two medications were not administered correctly. This was confirmed by the Registered Practical Nurse. [s. 8. (1) (b)]

2. The Home's Medication/Adverse Drug Reactions Policy Number 9-1.1, Revision Date November 2013, requires the following:
a)"Medication incidents will be reported."
b)"Medication incidents will be investigated from a patient safety/learning perspective. Action plans that include learning plans will be developed in response to medication incident reports.
c)"If the medication incident is related to a staff member practice or home process, the incident is to be thoroughly investigated and reviewed with the goal of getting to the root cause of the error."

The medication incident had not been documented on the applicable form and had been verbally reported to a Manager of the Home. Section (a), (b) and (c) of the policy were not followed. This was confirmed by the Acting Director of Care and the Administrator. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the medication incident involving Resident #001's medication being found at the bedside was (a) documented, together with a record of the immediate actions taken to assess and maintain the Resident's health (b) reported to the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the Resident's attending Physician and the pharmacy service provider, as evidenced by:

The Registered Practical Nurse revealed that she did not assess the Resident upon being notified of the Resident having missed medications, did not notify the attending Physician and other persons required to be notified per policy regarding medication incidents. This was confirmed by the Acting Director of Care. [s. 135. (1)]

Issued on this 29th day of April, 2014

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