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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 2, 2016	2016_247508_0001-A1	001895-16	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

ROSEANNE WESTERN (508), GILLIAN TRACEY (130)

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 25, 26, 27, 28, 29, February 2, 3, 4, 2016.

Inspections conducted concurrently with this complaint inspection: Complaint(s)- #027486-15 related to staffing levels, #031454-15 related to falls prevention and management, dining and snack service, #032486-15, related to falls prevention and management, care of resident post-fall, #026422-15, related to administration of drugs, and plan of care, Critical Incident(s)- # 003580-16 related to an unexpected death, #031589-15 related to missing narcotics.

During the course of the inspection, the inspector(s) spoke with Administrator; Director of Care; Assistant Director of Care; Director of Clinical Services; Resident Assessment Instrument (RAI) Coordinator; registered staff; Personal Support Workers (PSW's); Food Services Manager (FSM); restorative staff; dietary staff; residents and family members. During the course of this inspection, the inspectors: toured the home; reviewed meeting minutes; reviewed policies and procedures; reviewed resident health records; and observed residents in dining and care areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) According to the clinical record, resident #001 was toileted using a specific strategy. The written plan of care was updated, at which time the toileting interventions were changed in 2016. There were no assessments completed to warrant a change in the toileting plan.

The revised plan of care indicated the resident was no longer toileted, but checked and changed on a routine basis. An assessment completed by the Physiotherapist (PT) indicted there had been no changes to the resident's transferring/toileting needs upon return from hospital. The RAI Coordinator was interviewed and confirmed the care plan update related to toileting was not based on the assessment completed by the PT.

Resident #001's written plan of care was not based on an assessment of the needs and preferences of the resident. (Inspector #130). [s. 6. (2)]

2. The licensee failed to ensure that the resident's plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #103 was identified as having difficulty with eating and drinking independently in 2015. A referral had been made to the Registered Dietician (RD) to assess the resident. The RD's assessment documented in the clinical record indicated that the resident was to trial thickened fluids with an adaptive device and the assessment also identified that the resident required assistance with eating.

A review of the resident's plan of care for eating indicated that the resident could eat independently without the use of adaptive devices. An interview with the Food Service Manager on February 3, 2016, confirmed that the resident's plan of care was not based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

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

Resident #101 had a fall resulting in an injury in November 2015 and was transferred to hospital. The resident was re-admitted back to the

home with a treatment intervention to be done two weeks after readmission to the home.

A review of the resident's clinical record indicated that the treatment intervention had been partially completed nine days after what had been ordered by the Physician. Two days later, the treatment intervention had been completed which was 11 days after the date the treatment intervention should have been done.

It was confirmed by registered staff and clinical records that care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

A) The plan of care for resident #001 indicated that staff were to provide supplies and instruction for self oral hygiene and encourage the resident to perform proper oral hygiene each morning, after meals, at bedtime and prn (when needed). During this inspection, staff #010 confirmed that the resident had not received assistance with oral care on an identified morning. The Point of Care documentation indicated that the resident received assistance and/or encouragement twice per day and not as specified in the plan of care. (Inspector #130) [s. 6. (7)]

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

A) The plan of care for resident #102 indicated that staff were to provide total assistance for oral hygiene each morning, after meals, at bedtime and prn (when needed). The Point of Care documentation confirmed that the resident received assistance with oral hygiene twice per day and not as specified in the plan of care. (Inspector #130) [s. 6. (7)]

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 the plan of care is based on an assessment of the resident and the resident's needs and preferences and to ensure that care set out in the plan of care is provided to the resident as specified in the plan, 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. Where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Resident #101 was identified as a high risk for falls and was on the home's "falling leaf" program which identified residents at risk for falling. Staff confirmed on January 26, 2016, that resident #101 was a high risk for falls and should have a falling leaf posted outside the resident's room door.

During the initial tour of the home on January 25, 2016, it was observed that resident #101 did not have a falling leaf posted outside of their door and it was also observed not to be there on January 26, 2016.

It was confirmed by staff on January 26, 2016, that resident #101 was on the falling leaf program due to their risk for falls and that the program had not been complied with. [s. 8. (1) (b)]

2. The home's policy titled "Urine Specimen Collection 07-16" revised September 2013, directed staff to "allow resident to void into clean bedpan, urinal, or collection hat; take collected urine to bathroom or remove hat from toilet; and pour urine into specimen bottle and apply cap".

A) It was witnessed and reported by staff in 2015, that an attempt was made to obtain a urine specimen from resident #001, directly into a specimen bottle and not in accordance with the home's policy. This was confirmed during a discussion with staff on February 5, 2016. This non compliance was identified during the following Complaint Inspection #026422-15. (Inspector #130) [s. 8. (1) (b)]

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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Resident #301 was identified as a high risk for falls when admitted to the home in 2015, and required falls prevention equipment to minimize this risk.

Approximately two months later resident #103 had an unwitnessed fall and four days later the home implemented floor mats and a bed alarm to alert staff when the resident would attempt to get out of bed independently as the resident required assistance from staff.

The resident had another fall ten days after the bed alarm had been implemented and then another fall the following month. During the post fall assessment, it was identified that the bed alarm had not been functioning at the time of this fall. The home replaced the bed alarm.

It was confirmed during a review of the clinical record and during an interview with the restorative aide on January 28, 2016, that the bed alarm was not in a good state of repair when the resident fell. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was reassessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #100 had a fall which resulted in an injury on an identified date in 2015. The resident was transferred to hospital. The resident was hospitalized and then re-admitted back to the home. A pain assessment had been completed the following day which indicated that the resident was having pain.

The resident had on-going complaints of pain after re-admission and was receiving a PRN (when necessary) narcotic regularly to manage their pain. Another pain assessment was completed four days after the initial re-admission assessment indicating that the resident's pain was not being managed. The Physician ordered an additional narcotic to try to manage the resident's pain. The resident continued to complain of pain and the Physician then increased the dosage of the medication eight days after ordering the initial dose.

A review of the resident's clinical record indicated that the resident's pain had not been reassesed using a clinically appropriate assessment instrument over a two month period. During this time, the resident had on-going complaints of pain and pain medication changes and adjustments had been made. The resident also continued to receive additional break though pain medication PRN.

It was confirmed by the Assistant Director of Care (ADOC) during an interview on January 27, 2016, that the resident was not reassessed using a clinically appropriate assessment instrument specifically designed for this purpose when the resident's pain was not relieved by initial interventions. [s. 52. (2)]

2. Resident #002 was identified to have pain related to a chronic condition. Resident #002 was prescribed a regularly scheduled narcotic to manage the pain and also a PRN (when necessary) narcotic medication for breakthrough pain if the pain was not controlled. A review of the resident's Medication Administration Record (MAR), indicated that the resident required the PRN narcotic medication 11 times in addition to their regularly scheduled pain medication in a 31 day period.

A review of the resident's clinical records indicated that the resident had not been reassessed using a clinically appropriate assessment instrument during this time.

It was confirmed during an interview by registered staff on February 3, 2016, that the resident had not been reassessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain was not relieved by initial interventions. [s. 52. (2)]

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 when the resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of the following incident in the home, followed by the report required under subsection (4):
2. An unexpected death or sudden death, including a death resulting from an accident or suicide.

Resident #100 required total assistance of 1-2 staff for all aspects of care, including transfers and bed mobility. The resident was not considered a high risk for falls; however, on an identified date in 2016, resident #100 was discovered on the floor of their room.

The resident sustained some injuries and was sent out to hospital for further assessment. The resident returned back to the home and it was confirmed that the resident did not sustain any fractures as a result of the fall.

The resident’s condition declined after the fall, palliative care measures were implemented and the resident deceased.

An interview with the Director of Care on January 27, 2016, verified that the home did not report this incident to the Director. [s. 107. (1) 2.]

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 the Director is immediately informed of incidents in the home, including an unexpected death or sudden death, a death from an accident or suicide, followed by the report required under subsection (4), to be implemented voluntarily.

Issued on this 2nd day of March, 2016

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

Original report signed by the inspector.