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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 11, 2016 | 2016_247508_0012 | 020335-16 | Resident Quality Inspection |

## 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), KELLY HAYES (583)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): July 18, 19, 20, 21, 22, 25, 26, 27, 28, 2016.**

**The following inspections were conducted concurrently during this Resident Quality Inspection: Critical Incident inspections, log # 002489-15 related to responsive behaviours, log # 003294-16 and log # 022192-16 related to alleged abuse, log # 006025-16 related to a fall resulting in an injury, log #020619-16 related to an incident causing injury to a resident, complaint inspections: log # 003339-16, log # 006590-16 and log # 012585-16 related to resident care, log # 009299-16 related to an admission refusal, log # 019511-16 related to furnishings, log # 021157 -16 related to nutrition and hydration, log # 005883-16 related to medication administration. Follow up inspections, log # 019815-16, r. 3(1), resident's rights, log # 006069-16, r. 6(7), plan of care, log # 006070-16, s. 19(1), abuse and neglect, log # 006071-16 and log # 006072-16, s. 76(1), staff training. During this inspection the inspectors toured the home, observed meal services, reviewed relevant policies and procedures, complaint logs, internal investigative notes, resident clinical records, staffing schedules, time card reports, interviewed residents, staff and family.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Director of Informatics and Quality, Resident Assessment Instrument (RAI) Coordinator, Director of Clinical Services, Life Enrichment Manager, the Registered Dietitian, the Nutrition Manager, Nursing Unit Clerk, Office Manager, registered staff, Personal Support Workers (PSW), residents and family.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Maintenance**
**Admission and Discharge**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Residents' Council**
**Responsive Behaviours**

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

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 3. (1) | CO #001 | 2014_323130_0014 | 508 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (7) | CO #002 | 2015_214146_0015 | 508 |
| LTCHA, 2007 S.O. 2007, c.8 s. 76. (2) | CO #004 | 2015_214146_0015 | 130<br>508 |
| LTCHA, 2007 S.O. 2007, c.8 s. 76. (7) | CO #005 | 2015_214146_0015 | 130<br>508 |

## NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Resident #201 reported to the Director of Care (DOC) on an identified date in 2016, that while staff were providing care, staff #145 was rough with the resident while she provided care to the resident. The resident indicated that staff #145 had caused pain to the resident and upset the resident emotionally.

The DOC initiated an internal investigation and determined that the staff member was abusive to resident #201. During an interview with the resident, the resident verified this information to the Inspector.

It was confirmed by the DOC during an interview on July 27, 2016, that resident #201 was not protected from abuse by anyone.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection, log# 022192-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 19. (1)]

***Additional Required Actions:***

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

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**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:**

**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).**

**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 bed rail assessment completed in December, 2015, for resident #006, stated the resident did not require the use of bed rails. The Annual Minimum Data Set (MDS) Resident Assessment Instrument (RAI), section P4 (a, b), completed in April, 2016, by the RAI Coordinator was coded zero (0), which indicated bed rails were not used. The written plan of care revised by the Clinical Coordinator stated under "Bed Mobility" that one staff was to provide limited assistance with bed mobility, with minimal non weight physical assistance & support using guided maneuvering while encouraging the resident to hold onto "side rail" and turn from side to side and move to and from lying position while in bed.

On July 22, 2016, the RAI Coordinator confirmed the resident did not require bed rails and that the plan of care was not based on the assessment of the resident, with respect to the use of bed rails. On July 25, 2016, the Clinical Coordinator confirmed the intervention identified under bed mobility related to bed rail use was not consistent with resident's assessed needs. [s. 6. (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 plan of care is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.***

**WN #3: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

A verbal complaint regarding resident #100 had been brought forward to the Administrator on an identified date in 2016, regarding a staff member who had administered the resident's medication incorrectly.

An internal investigation had been completed and the complaint had been verified. A review of the home's Complaints policy, #06-05, with a revision date of November 2012, indicated that when a verbal complaint was received, the following will occur:

2. e) all verbal complaints will be entered on the Complaint Log.

A review of the home's 2016 Complaint Log verified that this complaint had not been documented in the complaint log as directed in their policy. This was also confirmed by the Administrator on July 28, 2016.

PLEASE NOTE: This non-compliance was identified during a complaint inspection, log# 005883-16, conducted concurrently during this Resident Quality Inspection (RQI). [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.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where bed rails were used, the resident was assessed.

A room observation and resident interview was completed with resident #003 during this inspection. Two quarter rails in a raised assist position were observed to be in place at the top of the bed. In an interview with resident #003, they indicated that it was their preference to have the bed rails and that they used the bed rails to assist them with getting in and out of bed and to reposition them self while in bed.

The "PLS Bed Rail Assessment v2" completed on an identified date in 2015, identified that the resident did not require bed rails. The quarterly "Section P: Special Treatments and Procedures" assessment completed on an identified date in 2016, and resident #003's plan of care identified there were no bed rails in place.

In an interview with the Director of Clinical Services on July 25, 2016, it was confirmed that resident #003 had two assist rails in place that were being used as a personal assistance services device. It was also confirmed that there was no assessment of resident #003's assist bed rails in the plan of care. [s. 15. (1) (a)]

***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 where bed rails are used, the resident is assessed, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in 2016, PSW #117 was witnessed "shouting" at resident #102. The home conducted an internal investigation related to the incident, which included an assessment of the resident and notification to the resident's substitute decision maker (SDM). The DOC confirmed there was no documentation in the resident's clinical record related to the incident, the assessment of the resident, nor the actions taken.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection, log #003294-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 30. (2)]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #201 reported to staff on an identified date in 2016, that during care that same day, staff #145 had been rough with the resident which resulted in pain. The resident was upset about the incident which caused the resident to cry.

This incident was reported to the DOC and an investigation into the incident was initiated. According to the Critical Incident (CI) report submitted by the home, the DOC, the Assistant Director Of Care (ADOC), and the Life Enrichment Manager, had to provide emotional support to the resident due to the incident.

A review of the resident's clinical record revealed that the interventions provided to the resident and the resident's responses to these interventions had not been documented.

It was confirmed by the DOC during an interview on July 27, 2016, that the interventions provided and the resident's responses to these interventions had not been documented.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection, log #022192-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations**
**Every licensee of a long-term care home shall ensure that,**
**(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and**
**(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours.

It had been identified that resident #003 had responsive behaviours which required a specified intervention. This specific intervention had been implemented in order to meet the need of resident #003 on certain shifts to minimize risks associated with the resident's responsive behaviour.

A review of the staffing schedules and time card reports over a three month period in 2016, indicated that on a shift in May, 2016, this intervention for resident #003 had not been implemented.

It was confirmed during an interview with the DOC on July 27, 2016, that the procedures and interventions developed had not been implemented on an identified date in May 2016, to assist resident #003 with their responsive behaviours.

PLEASE NOTE: This non-compliance was identified during a complaint inspection, log #012585-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 55. (a)]

***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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours, to be implemented voluntarily.***

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**WN #7: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that proper techniques were used for residents who required assistance with eating, including safe positioning.

During this inspection, Inspector #583 entered resident #100's room and observed the resident in bed with a meal tray and no staff present. Staff #066 returned to the room to feed the resident. It was confirmed that the resident's diet texture was downgraded for lunch due to an identified concern. Inspector #583 observed staff #066 feed resident #100 in bed with the head of the bed at approximately 60 degrees. The resident was positioned in a fetal position on their right side and had slid down the bed.

The Director of Clinical Services observed resident #100 and it was confirmed that resident #100 was not positioned safely for feeding. Resident #100's plan of care identified nutritional concerns and that the resident required extensive assistance with feeding including weight bearing support. In an interview with the Director of Clinical Services on July 27, 2016, it was confirmed that it was unsafe to leave the resident unattended with their meal tray. [s. 73. (1) 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 ensure that proper techniques are used for residents who require assistance with eating, including safe positioning, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the physician's order and the E-MAR (Electronic Medication Administration Record) for resident #100 indicated that the resident was to have medication applied in the evening and removed every morning.

On an identified date in 2016, the Registered Practical Nurse (RPN) responsible for the medication administration for resident #100, did not administer the resident's medication as directed in the physician's order.

This was discovered by the resident's family member who then brought it to the attention of the Administrator that same day. An internal investigation confirmed that the RPN did not follow the directions when she administered the resident's medication.

It was confirmed by the DOC during an interview on July 26, 2016, that drugs were not administered in accordance with the directions for use specified by the prescriber.

PLEASE NOTE: This non-compliance was identified during a complaint inspection, log # 005883-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

During a tour of the home on July 18, 2016, at 1130 hours, the following were observed in the common area tub/shower rooms.

On Lancaster Park, the bottom of the tub was observed to have dust/grime and hair and one white brush was identified to be unlabelled with hair in it. Staff #189 observed and confirmed that the tub was dirty and the used brush was unlabelled.

On Montebello Park, three white brushes were identified to be unlabelled with hair in them and one deodorant was used and unlabelled. Staff #106 observed and confirmed there were three brushes and one deodorant that were unlabelled and used.

On Centennial Park, the bottom of the tub was observed to have dust/grime and hair. Staff #187 observed and confirmed the tub was dirty.

On Morning Star Mill Park, the bottom of the tub was observed to have dust/grime and hair in it. Staff #182 observed and confirmed the tub was dirty.

On Woodland Park, one white brush was identified to be unlabelled and used. Staff #093 observed and confirmed there was an unlabelled used brush.

In an interview with the DOC on July 28, 2016, it was confirmed the home's tub disinfection procedure was to be disinfected after each resident use and personal care items in common areas were to be labelled. [s. 229. (4)]

***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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home**

**Specifically failed to comply with the following:**

**s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,**
**(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).**
**(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).**
**(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #101's application for admission was approved unless,

(a)the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care
requirement or; (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

A) On an identified date in 2016, the home provided applicant #101 with a written letter indicating that their acceptance for admission had been declined because they had an identified health care concern and because the home did not have equipment available for their use.

The reason for this refusal did not meet the grounds for withholding approval as specified in the legislation.

PLEASE NOTE: This non-compliance was identified during a complaint inspection, log #009299-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 44. (7)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the policies and procedures relating to nutrition care and dietary services were implemented.

During this inspection, resident #100 was observed being fed a specific diet texture for lunch, in bed by staff #141. Resident #100 was observed holding food in their mouth. The documentation on the meal report identified resident #100 took zero to 25 percent of their lunch.

On another date during this inspection, resident #100 was observed being fed the same diet texture in bed by staff #066. The Nutrition Manager and Director of Clinical Services also observed the resident and confirmed this.

Resident #100's physician's order and meal service report used by dietary staff to identify the resident's diet requirements identified the resident was on another type of diet texture, not what had been observed. A review of resident #100's progress notes revealed that they did not contain any information related to a change in diet.

The "Dysphagia Management" policy #06-08, October 2013, directed the interdisciplinary team to complete a nutrition referral for the Registered Dietitian (RD) to assess the resident for residents with swallowing difficulties. The policy identified any changes to diet texture would be communicated to the interdisciplinary team in the physician's order section of the chart, progress notes and nutritional profile.

In an interview with the Nutrition Manager on July 27, and the RD on July 28, 2016, it was confirmed a nutrition referral was not completed for resident #100 and the RD was not aware the resident was receiving a different diet texture. It was verified that there was no communication related to the diet texture change in the resident's plan of care. It was confirmed that the policies and procedures relating to dysphagia were not implemented. [s. 68. (2) (a)]

**Issued on this 19th day of September, 2016**

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

**Original report signed by the inspector.**

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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ROSEANNE WESTERN (508), GILLIAN TRACEY (130), KELLY HAYES (583) |
| **Inspection No. / No de l'inspection :** | 2016_247508_0012 |
| **Log No. / Registre no:** | 020335-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Aug 11, 2016 |
| **Licensee / Titulaire de permis :** | HENLEY HOUSE LIMITED<br>200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9 |
| **LTC Home / Foyer de SLD :** | THE HENLEY HOUSE<br>20 Ernest Street, St. Catharines, ON, L2N-7T2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Namarta Namarta |

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

**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2015_214146_0015, CO #003;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that all residents, including resident #201, are protected from abuse by anyone and to ensure that all residents are not neglected by the licensee or staff.

The plan shall include but not be limited to the following:

1. Mandatory re-education for all staff on abuse.
2. Mandatory re-education for all staff on the Resident's Bill of Rights.
3. Quality monitoring activities to ensure ongoing compliance with the home's abuse policy.

The plan shall be submitted to Roseanne.Western@ontario.ca no later than end of business day on September 2, 2016.

**Grounds / Motifs :**

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s.19(1) of the Act, in respect to the actual harm to resident #201, the scope of one isolated incident, and the Licensee's history of non-compliance (CO) on February 25, 2016, related to abuse.

Resident #201 reported to the Director of Care (DOC) on an identified date in 2016, that while staff were providing care, staff #145 was rough with the resident while she provided care to the resident. The resident indicated that staff #145 had caused pain to the resident and upset the resident emotionally.

The DOC initiated an internal investigation and determined that the staff member was abusive to resident #201. During an interview with the resident, the resident verified this information to the Inspector.

It was confirmed by the DOC during an interview on July 27, 2016, that resident #201 was not protected from abuse by anyone.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CI) inspection, log# 022192-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 19. (1)]

(508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 28, 2016

## 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 August, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Roseanne Western

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