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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2018	2018_661683_0009	005996-18	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

LISA BOS (683), GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 26, 28, 29, April 3, 4, 5, 10, 11, 12, 13 and 18, 2018.

The following intakes were completed concurrently with the Resident Quality Inspection:
011141-17 - complaint related to hospitalization and change in condition
011184-17 - complaint related to falls prevention and management
001155-18 - complaint related to the prevention of abuse and neglect, skin and wound, pain management, personal support services, transferring and positioning
004447-18 - complaint related to the prevention of abuse and neglect
004859-18 - complaint related to medication and sufficient staffing
029658-17, CIS #2909-000024-17 - related to the prevention of abuse and neglect
002943-18, CIS #2909-000010-18 - related to the prevention of abuse and neglect and falls prevention and management
003339-18, CIS #2909-000011-18 - related to the prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian, Physiotherapist, Registered Staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection the inspectors toured the home, reviewed resident clinical records, policies and procedures, investigation notes, training and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. 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.

A) According to the written plan of care, resident #010 required an identified level of assistance with their oral hygiene needs at specific times.

The Point of Care (POC) records reviewed for an identified time period revealed that the identified level of assistance was being provided, however; it was not provided at all of the specific times as specified in resident #010's written plan of care.

On an identified date, staff #147 and #152, confirmed in interviews, that the resident was provided an identified level of assistance with their oral hygiene needs at specific times and not at other specific times.

The care set out in the written plan of care for resident #010, specifically related to oral care, was not provided to the resident as specified in the plan.

Please note: This non-compliance was issued as a result of complaint inspection: 001155-18 and critical incident inspection: 029658-17 related to 2909-000024-17, which were conducted concurrently with the RQI.

B) According to the written plan of care, resident #024 required an identified level of assistance with their oral hygiene needs at specific times.

The POC records reviewed for an identified time period revealed that the identified level of assistance was being provided, however; it was not provided at all of the specific times as specified in resident #024's plan of care.

Resident #024 and Personal Support Worker (PSW) #147 confirmed in interviews, that the resident was provided an identified level of assistance with their oral hygiene needs at specific times and not at other specific times, as specified in their written plan of care.

Please note: This non compliance was issued as a result of complaint inspection: 001155 -18 and critical incident inspection: 029658-17 related to 2909-000024-17, which were conducted concurrently with the RQI.

2. The licensee failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, different approaches were considered in the revision of the plan of care.

Resident #018's written plan of care indicated that they were at an identified risk of falls related to a specific disease process and a history of falls. Review of the clinical record identified that on an identified date, resident #018 had a fall in an identified room. The resident had a second fall on the same identified date, in the same room as the previous fall, which resulted in three identified injuries. Three days later, resident #018 sustained a third fall in a different identified room.

Resident #018's written plan of care was reviewed and it identified specific interventions in place to prevent falls. Review of the revision history of the care plan identified that resident #018's care plan was reviewed after the three identified falls, however; all of the identified interventions were in place prior to the falls. There were no new falls prevention interventions added after any of the identified falls on the identified dates.

Interview with PSWs #149, #166 and #204 and Registered Practical Nurse (RPN) #291 identified that resident #018 was known to self-transfer. Resident #018's written plan of care identified that they would do unsafe transfers and that staff needed to monitor them closely to ensure that they were safe.

Interview with the DOC on an identified date, acknowledged that different approaches were not considered in the revision of the plan of care for resident #018 when the falls prevention interventions were not effective.

Please note: This non-compliance was issued as a result of complaint inspection: 006763-18, which was conducted concurrently with the RQI.

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 is being reassessed and the plan of care is being revised because care set out in the plan is not effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the physical functioning and the type and level of assistance that was required relating to activities of daily living, including hygiene and grooming.

Resident #018's written plan of care indicated that they were at an identified risk of falls related to a specific disease process and a history of falls. Review of the clinical record identified that on an identified date, resident #018 had a fall in an identified room. The resident had a second fall on the same identified date, in the same room as the previous fall, which resulted in three identified injuries. Three days later, resident #018 sustained a third fall in a different identified room. A progress note documented four days after the last fall, identified that the resident was demonstrating pain and the home ordered an identified assessment to assess the cause of the resident's pain.

Interview with PSWs #149, #204 and #166, RPN #291 and complainant #328 identified that resident #018 used an identified device for toileting which was replaced with a different device with the same function, in an identified month. Interview with the DOC on an identified date, indicated that all of the identified devices were switched to the replacement device with the same function for infection prevention and control reasons.

Review of resident #018's clinical record did not identify any assessments for the use of the identified device or the replacement device and did not identify that the identified device or replacement device was used.

In an interview with the DOC on an identified date, they indicated that the home did not do assessments for the use of the identified device or the identified replacement device and indicated that they did not put them in the care plan for most residents. They indicated that the identified device and identified replacement device were provided to residents at their request, or at the request of front line staff.

The home did not ensure that the plan of care was based on an interdisciplinary assessment for resident #018's identified toileting device, that was used to improve their physical functioning as part of their activities of daily living.

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, at a minimum, interdisciplinary assessment of the physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

According to the written plan of care, resident #010 was at risk for impaired skin integrity related to an identified diagnosis.

A review of the Skin and Wound assessments completed for alterations in skin to an identified area revealed the affected area was not consistently reassessed weekly when it was clinically indicated.

The area of impaired skin integrity to the identified area was assessed on an identified date, and not reassessed until 14 days later. The area was assessed again on an identified date, and not reassessed until 10 days later. The area was again assessed on an identified date, and not reassessed until 14 days later. The affected area was not reassessed until 42 days later, on an identified date, at which time the assessment indicated the area was healed.

The skin and wound assessment notes revealed that on an identified date, the resident had impaired skin integrity to a different area. There was no reassessment or follow-up documentation to indicate whether or not the area had healed or whether treatment was still required.

On an identified date, the resident was assessed to have impaired skin integrity to two other identified areas. There was no reassessment or follow-up documentation to indicate whether or not the area had healed or whether treatment was still required.

On an identified date, the resident was assessed to have impaired skin integrity to another identified area. The area was not reassessed until an identified date, at which time the assessment indicated the area was healed.

The skin and wound assessments were reviewed with the DOC on an identified date, at which time it was acknowledged that areas of altered skin integrity had not been reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Please note: This non-compliance was issued as a result of complaint inspection : 001155-18 and critical incident inspection: 029658-17 related to 2909-000024-17, which were conducted concurrently with the RQI.

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 a resident exhibiting alter skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, when clinically indicated, to be implemented voluntarily.

WN #4: 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 :

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

A) Resident #012 had a physician's order to receive an identified medication an identified number of times each day for an identified condition. On an identified date, staff #285 administered the identified medication at an identified time; however, the resident was not to receive the medication until three hours later than it was administered. An interview with the Assistant Director of Care (ADOC) on an identified date and a review of the medication incident report confirmed the medication was administered at the wrong time. There were no ill effects to the resident as a result of the medication not being administered in accordance with the directions specified by the prescriber.

B) Resident #013 had a physician's order to receive an identified medication at an identified dose, an identified number of times each day for an identified condition. On an identified date, staff #281 administered the identified medication at an identified dose to the resident, which was less than the dose prescribed by the Physician. An interview with the ADOC on an identified date and a review of the medication incident reports confirmed the resident received the incorrect dose of the identified medication on an identified date. There were no ill effects to the resident as a result of the medication not being administered in accordance with the directions specified by the prescriber.

C) On an identified date, staff #326 reported to the ADOC that three identified medications were found on resident #014's night stand. The ADOC acknowledged that the home's internal investigation was inconclusive in identifying what day the incident occurred and what nurse was responsible for failing to administer the medications.

The ADOC confirmed in an interview conducted on an identified date that the identified medications were prescribed for this resident, a medication incident had in fact occurred and that as a result, resident #014 did not receive their medications as prescribed.

Residents #012, #013 and #014 did not receive their medications in accordance with the directions for use specified by the prescriber.

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.

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 :

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.

The home's assessment tool titled: "Weekly Treatment Reassessment Form," directed staff to describe the current status of area(s) being treated.

According to the written plan of care, resident #010 was at risk for impaired skin integrity related to an identified diagnosis.

A review of the Weekly Treatment Reassessment forms from an identified time period revealed that on five occasions, staff completing the assessment form did not consistently document a description of the affected area being treated.

It was confirmed in an interview with the DOC on an identified date that not all action taken with respect to the resident, specifically the assessment of impaired skin, was documented.

Please note: This non-compliance was issued as a result of complaint inspection: 001155-18 and critical incident inspection: 029658-17 related to 2909-000024-17, which were conducted concurrently with the RQI.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that residents were transferred using safe transferring and positioning techniques.

Review of the home's critical incident report, internal investigation notes and staff interviews indicated that on an identified date, PSW #147 and PSW #327 took resident #017 to the bathroom and transferred them onto the toilet using an identified mechanical lift. The resident was provided the call bell to use when they were ready. PSW #147 left the bathroom and PSW #327 remained in the bedroom area. PSW #147 reported that after approximately 10 minutes they heard the call bell ring and it was cancelled and then it rang again and was cancelled. PSW #147 witnessed PSW #327 coming down the hallway from the direction of resident #017's room. PSWs #147 and #152 went to resident #017's room to transfer them off of the toilet. When PSWs #147 and #152 entered resident #017's room, they found that the resident was transferred off of the toilet. The resident identified they were transferred off of the toilet by a staff member who fit the description of PSW #327 and acknowledged that the staff member was rough with them.

Review of the clinical record for resident #017 identified that they were at risk of falls. Review of resident #017's written plan of care and physiotherapy assessment from an identified date, indicated that the resident required two staff to provide an identified level of assistance for toileting needs and two staff to provide an identified level of assistance when using an identified mechanical lift for transfers.

The home's internal investigation, which included review of video surveillance, concluded that PSW #327 transferred resident #017 using the identified mechanical lift off of the toilet without the assistance of a second staff member.

Interview with the DOC on an identified date confirmed that PSW #327 did not use safe transferring and positioning techniques for resident #017 on the identified date.

Please note: This non-compliance was issued as a result of critical incident inspection: 002943-18 related to 2909-000010-18, which were conducted concurrently with the RQI.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

The licensee failed to ensure that where a resident was being restrained by a physical device under section 31 of the Act, that the resident was released from the physical device and repositioned at least once every two hours.

Review of the clinical record for resident #004 identified that they required an identified device at all times for safety as a restraint. Resident #004 was observed on an identified date, for approximately two and a half hours with the identified device applied correctly. During the observation period, the identified restraint device was not released and the resident was not repositioned by staff. Review of the POC documentation from the date of the observation did not identify that the resident's restraint device was released and reapplied between a time period of approximately five and a half hours.

Interview with PSW #180 on an identified date indicated that they were approximately one hour into their shift and acknowledged that they had not yet provided care to resident #004 that day. Interview with PSW #146 on an identified date, indicated that they were responsible for the care of resident #004 on the date of the Inspector's observation; however, they could not recall if they released the resident's identified restraint device that day between the identified observation period.

Interview with PSW #164 and RPN #285 on an identified date, indicated that the home's expectation was that resident's with the identified restraint device should be released and repositioned at least every two hours. RPN #285 reviewed, on request, the POC documentation for resident #004 on the identified date of observation and confirmed that resident #004's restraint device should have been released during the identified observation period.

Interview with the DOC on an identified date indicated that it was the home's expectation that residents who were restrained by a physical device were released from their restraint and repositioned at least once every two hours.

The home did not ensure that resident #004 was released from their seat belt restraint and repositioned at least once every two hours on an identified date.

Issued on this 30th day of May, 2018

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

Original report signed by the inspector.