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

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 # / No de registre	Type of Inspection / Genre d'inspection
May 16, 2018	2018_720130_0008	005468-18	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

GILLIAN HUNTER (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): March 19, 20 and 21, 2018.

The following complaint inspections were conducted concurrently with this inspection: 004859-18 related to medication administration and sufficient staffing; 005462-18 related to abuse prevention, medication administration, sufficient staffing and bathing.

The following onsite inquiries were conducted concurrently with this inspection: 001158-18 related to abuse prevention, medication administration, sufficient staffing and bathing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), registered staff, personal support workers (PSWs) and residents.

During this inspection, clinical records were reviewed, medication administration was observed and incident reports were reviewed.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 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.

The following complaints: 004859-18, 05462-18, 005468-18 and 001158-18, alleged that residents were not receiving their medications on time due to insufficient staffing.

The plan of care for resident #003 revealed they required a specific medication related to their diagnosis.

According to the Electronic Medication Administration Record (E-MAR). The medication was to be administered at specified times and the nurse was to take specific action under certain circumstances. According to the E-MAR, on an identified date in 2018, the medication was not administered at the correct time.

Staff #100 confirmed in an interview in 2018, that resident #003 did not receive their medication as prescribed.

B) The plan of care for resident #001 revealed they required a specific medication related to their diagnosis.. The medication was to be administered at specified times and the nurse was to take specific action under certain circumstances. According to the E-MAR, on an identified date in 2018, the medication was not administered at the correct time.

Staff #100 confirmed in an interview in 2018, that resident #001 did not receive their medication as prescribed.

Please note: This non compliance was issued as a result of the following complaint inspections: 004859-18 and 005468-18. (Inspector #130). [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 were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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. (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 did not ensure that the 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 #009, revealed they were high risk for skin impairment and had areas of impaired skin. There was a written physician's order in place directing staff to complete a specific treatment.

According to the plan of care, a treatment was provided on an identified date in 2018 and was scheduled to be re-done a few days later. An E-MAR administration note recorded on the date the treatment was to be re-done indicated it was not done due to time constraints.

Staff #100 confirmed in an interview, they did not complete the treatment on the scheduled date because they were short staffed. The E-MAR and progress notes confirmed the treatment was not completed until the day after the scheduled date.

Care was not provided to resident #009, as specified in the plan of care.

Please note: This non compliance was issued as a result of the following complaint inspection: 004859-18 and 005468-18. (Inspector #130). [s. 6. (7)]

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Issued on this 16th day of May, 2018

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

Original report signed by the inspector.