Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 19, 2021	2021_704682_0005	002935-20, 016965-20, 018383-20, 021811-20, 022979-20, 000185-21	Critical Incident System

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 Catherines ON L2N 7T2

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

AILEEN GRABA (682), GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 18, 19, 23, 24, 25, 26, 29, 30, 31, April 1, 6 and 7, 2021.

This inspection was conducted with the following intakes:
002935-20 (2909-000003-20) related to responsive behaviour and prevention of abuse and neglect

016965-20 (2909-000014-20) related to falls
018383-20 (2909-000015-20) related to hospitalization and change in condition
021811-20 (2909-000020-20) related to safe transfer and positioning techniques
022979-20 (2909-000002-20) related to falls
000185-21 (2909-000001-21) related to falls

The following Complaint intakes were completed concurrently with this Critical Incident System inspection
021192-20 related to neglect, bathing and continence care
022219-20 related to plan of care and change in condition
002161-21 related to neglect, plan of care, reporting and complaints

Please note: Findings of non-compliance related to Long-Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 6 (7) related to plan of care was identified in this inspection and has been issued in complaint Inspection Report 2021_704682_0004 which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Office Manager, Acting Life Enrichment Manager, Behaviour Supports Ontario (BSO) staff, front entrance screeners, housekeeping, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) toured the home, reviewed investigative notes, staffing schedules, resident health records, meeting minutes, program evaluations, policies and procedures, complaints binder/logs, Critical Incident System (CIS) submissions and observed Infection Prevention and Control (IPAC) practices, residents and provision of care.

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

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 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	Légende 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. 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 :

1. The licensee failed to ensure that staff used safe positioning techniques when assisting a resident.

A Personal Support Worker (PSW) was providing care and repositioned a resident resulting in an injury. The resident's plan of care indicated that they required assistance with activities of daily living (ADL's). The PSW confirmed that the resident's plan of care was not followed. Because the PSW did not use safe positioning techniques when providing care, the resident sustained an injury.

Sources: Resident electronic medical record (EMR), the home's investigation notes, Interview with PSW [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours,

One resident slapped another resident in the face resulting in an injury.

The home's Responsive Behaviours policy stated the following:
3. "If responsive behaviour is observed, a more in-depth interdisciplinary assessment of the behaviour will be undertaken using any one or combination of the following assessment processes/tools:
 a. Dementia Observation Scale
 b. Cohen Mansfield Agitation Inventory
 c. Tool used by the local psychogeriatric outreach/support program
The assessments will help to identify factors that could potentially trigger an altercation with another resident. Once these triggers are identified, staff is to implement interventions that will minimize the risk of altercation."

Progress notes identified previous altercations involving both residents. The resident's care plans did not have any further strategies developed or implemented as a result. A Registered Nurse (RN) stated both residents had responsive behaviours. By not developing and implementing effective strategies to reduce responsive behaviours, the residents were involved in a subsequent altercation that resulted in resident injury.

Sources: Responsive Behaviours policy, electronic medical records, Interview with RN and other staff. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

Issued on this 27th day of April, 2021

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

Original report signed by the inspector.