Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: May 5, 2023

Inspection Number: 2023-1393-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Henley House Limited

Long Term Care Home and City: The Henley House, St Catherines

Lead Inspector	**Inspector Digital Signature**
Daria Trzos (561)	Daria Trzos Digitally signed by Daria Trzos Date: 2023.05.30 15:37:47 -04'00'

Additional Inspector(s)
Cathy Fediash (214)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 24, 27-31, 2023 and April 3-5, 11-14, 17, 18 , 2023. The inspection occurred offsite on the following date(s): April 6, 2023.

The following intake(s) were inspected:
- Intake: #00007802 - Complaint related to multiple care areas.
- Intake: #00007810 - Complaint related to cooling requirements, IPAC and other concerns
- Intake: #00007887 - Complaint related to multiple care concerns.
- Intake: #00009298 - Complaint related to multiple care concerns.
- Intake: #00012936 - Complaint related to housekeeping.
- Intake: #00016815 - Complaint related to air temperatures.
- Intake: #00019179 - Complaint related to missing personal item.
- Intake: #00014108 - [CI: 2909-000107-22] Fall of resident resulting in injury.

The following intakes were completed in this inspection: Intake # 00008003, CI #2902-000089-22, Intake #00013849, CI #2909-000101-22, Intake #00001357, CI #2909-000048-22, Intake #00004678, CI #2909-000059-22, Intake #00005952, CI #2909-000050-22, Intake #00006564, CI #2909-000014-22, Intake #00006757, CI #2909-000034-22, Intake #00007253, CI #2909-000018-22 related to falls with injuries.

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident related to skin and wound.

Summary and Rationale
A resident had an altered skin integrity. Personal Support Worker (PSW) staff and registered staff indicated that an intervention was implemented to prevent the wound from deteriorating. The written plan of care did not include this intervention and was not added to the task for staff to document that it was being done. The Associate Director of Care (ADOC) confirmed that it should have been included in the written plan of care and added to the task.

Failing to have the written plan for the resident related to an intervention for prevention of wounds increased the risk for staff not being aware that this intervention was in place.

Sources: Review of resident's plan of care; interview with PSW and registered staff and ADOC.
[561]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Resident #002 had an altered skin integrity. The wound assessment and the written plan of care dated on the same day were not consistent with each other in relation to the description of the altered skin integrity. Resident #003 had an altered skin integrity after an injury and the assessments did not complement each other. The description of the altered skin integrity was different from how it was described in the progress notes by different registered staff members. This was confirmed by registered staff and the ADOC.

If assessments were not consistent with each other, it may have increased the risk of staff making an error in providing the correct treatment.

Sources: Review of both resident's health records; interview with staff.
[561]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that resident's plan of care was reviewed and revised when their care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary
A resident had an altered skin integrity which has healed. There was no more treatment being provided. Clinical records indicated that the order for the treatment was not discontinued when the wound healed, and treatment was no longer necessary. The electronic treatment administration record (eTAR) identified that staff still signed for the application of the dressing. The written plan of care was not updated to reflect the status of the wound.

The ADOC confirmed that once a wound was improving or was healed and no longer needed a

treatment, the order should have been discontinued and the care plan should have been revised.

Sources: Review of resident's plan of care; observation; interview with registered staff and ADOC.
[561]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A resident was observed to have an altered skin integrity. PSW staff indicated that the resident had this for some time and they were applying barrier cream. There was no documentation regarding this nor any assessments completed in relation to this skin concern. The lead for the skin and wound care program/ADOC indicated that they were not aware of this skin issue and that a skin assessment should have been completed when the staff first discovered it.

Failing to assess an altered skin integrity increased the risk of deterioration and proper treatment application for improvement.

Sources: Observations; clinical record review; policy "Skin Care Program Overview" (November 2013); interview with the resident, PSW staff and the ADOC.
[561]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee has failed to ensure that a resident exhibiting altered skin integrity, with signs of deterioration received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

Rationale and Summary
A resident had a fall and was sent to the hospital for a treatment of the injury they sustained. They returned to the home with an altered skin integrity. On one of the days it was observed that the altered skin integrity had signs of deterioration. There was no action taken for the deterioration of the altered skin integrity.
The ADOC confirmed that registered staff should have informed the physician about the deterioration in order that treatment and interventions could be implemented.

When actions were not taken when a wound was deteriorating it may have increased the risk for further complications.

Sources: Clinical record review; review of home's policy "Wounds-pressure ulcers" (March 2015); interview with ADOC.
[561]

WRITTEN NOTIFICATION: Implementation of policy

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The licensee has failed to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions, was implemented in the home.

O. Reg. 246/22 s. 11. (1) (b) requires the licensee to have, instituted or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee was required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with.

Rationale and Summary
The home's Physician/Prescriber Orders policy stated that all orders written by health care practitioners that have within their scope of practice the skill set to order pharmaceuticals and other specialty products, diagnostic tests and other treatments for a resident were to be fully processed by registered staff within 24 hours of being written. Furthermore, when telephone orders were received registered staff were to clearly document the order on the Physician/Registered Nurse in extended Class RN(EC) Order form provided by the pharmacy and clearly identify that this was a telephone order. The Physician/RN (EC) was responsible on their next day in the home to countersign the order written by the nurse.

A resident returned to the home from hospital with an identified treatment that needed a physician order to be processed. A telephone order was obtained by a registered staff; however, the order was not processed as indicated in the home's policy.

Failing to follow the process of obtaining telephone orders from the physician may have increased the risk in making transcription errors.

Sources: Review of clinical records; home's policy "Physician/Prescriber Orders" (November 2013); interview with registered staff and ADOC.
[561]

WRITTEN NOTIFICATION: Documentation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has 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.

Rationale and Summary
A resident returned to the home from the hospital with direction to set up a follow up appointment at a clinic for re-assessment. The home arranged the appointment. There was no documentation found to identify whether the resident's substitute decision maker (SDM) was notified of this appointment. The ADOC confirmed that any such interventions and notification to SDM should have been documented.

Sources: Clinical record review; interview with registered staff and ADOC.
[561]

WRITTEN NOTIFICATION: Training

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual

training in all the areas required under subsection 82 (7) of the Act.

O. Reg 746/22, s. 261(1) 2. indicated that skin and wound care was one of the areas in which training shall be provided to all staff who provided direct care to residents.

Rationale and Summary
Records indicated that in 2022, 70 out of 79 [89 Per cent (%)] PSWs and 32 out of 50 (64%) registered staff in the home completed training related to the skin and wound program. This was confirmed by the Vice President (VP) of Operations/DOC.

Failing to complete training in skin and wound increased the risk of staff not being aware of correct procedures related to skin and wound and placed residents at risk.

Sources: Training records; interview with VP of operations/Acting DOC.
[561]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee has failed to comply with their hydration program to ensure that interventions to mitigate and manage risks for a resident, were implemented.

In accordance with Ontario Regulation, 246/22, s.11. (1) b, the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system, was complied with.

Specifically, staff had not complied with the policy, “Hydration Program”.

Rationale and Summary
The home’s policy Hydration Program (revised September 2022), indicated registered staff were to ensure that the names of residents who were below the total daily limit for fluid intake, were passed on to the whole team at shift change or huddle to ensure that fluids were encouraged throughout the day.

The VP of Operations, indicated that any resident who consumed less than 1000 milliliters (mls) of fluids per day, should be identified unless they had been assessed to not require that quantity. They indicated for resident’s who met this requirement of the policy, registered staff on the night shift were to

document this information in the huddle binder, that was located on each unit. The information was then discussed at shift change so staff were aware to implement interventions for low fluid intake.

A resident's electronic nutritional care plan indicated they were a moderate nutritional risk and had a minimum fluid goal per day.
A review of their clinical record indicated the resident had not met their daily fluid goal on identified days.

The huddle binder contained a template document. The template had not included an area to document residents who had consumed fluid amounts below their total daily intake. This resident's name had not been documented on the huddle templates for the above periods of time they were identified as having consumed less than 1000 mls, as specified in the licensee's policy.

Assistant Director of Care (ADOC) #103, confirmed the home's dehydration program policy had not been complied with.

When the hydration policy is not followed as written, this has a potential for fluid interventions to not be identified and implemented and can put the resident at risk for dehydration.

Sources: Resident's clinical records; PCC Look Back Report; Huddle binder; the licensee's Hydration Program policy (revised September 2022); and interviews with the VP of Operations, and ADOC #103. [214]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee has failed to ensure that there was a documented record for a complaint related to the care provided to a resident, that had included every date on which any response was provided to the complainant, and a description of the response.

Rationale and Summary
On an identified date in 2022, the VP of Operations received a verbal complaint related to resident. The complainant had been unable to recall if they had received a response to their complaint.

The VP of Operations and the Executive Director (ED) confirmed the home's complaint binder for an

identified month in 2022, was empty and had not contained any complaint forms that included every date on which any response was provided to the complainant, and a description of the response.

It was confirmed the Complaint Log for the 2022 year, which was a summary of all complaints for the year and kept in the front of the complaint binder, was also missing and unable to be located.

Failure to ensure there was a documented record of this complaint as required, resulted in the inability to know if the complaint had been resolved and increased the potential for further complaints.

Sources: Resident's clinical records; review of the home's complaint binder, and interviews with the ED and other staff.
[214]

COMPLIANCE ORDER CO #001 Skin and Wound Assessments

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 55 (2) (b) (iv) [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit, and implement a plan to ensure a resident who had altered skin integrity is reassessed at least weekly by a member of the registered nursing staff.

The plan must include but is not limited to:

- The necessary corrective actions, and the person(s) responsible for implementing them.
- The type and frequency of quality monitoring, including who will be responsible and how it will be documented.
- How the plan will be evaluated and reassessed for effectiveness, and the frequency of the evaluations.

Please submit the written plan for achieving compliance for inspection #2023-1393-0004 to Daria Trzos (561), LTC Homes Inspector, MLTC, by email to HamiltonDISTRICT.MLTC@ontario.ca by May 19, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
i) A resident had two wounds that were not reassessed at least weekly by registered staff. There were multiple wound assessments missing for a period of three months. When the eTAR was reviewed for the months mentioned the staff were signing that the assessments were completed.
Registered staff indicated that assessments were missed because they had many new staff and agency staff who were not always completing them.

Failing to assess the wounds weekly may have increased the risk of wounds to deteriorate.

Sources: Resident's health records including weekly skin and wound assessments, written plan of care, progress notes, eTAR; interview with registered staff and ADOC.
[561]

ii) A resident returned to the home post hospitalization and returned with an altered skin integrity. The resident's altered skin integrity was not reassessed weekly after it had deteriorated and required further treatment. Registered staff and the ADOC confirmed that wound assessments were to be completed on weekly basis.

Failing to assess the wounds weekly may have increased the risk of wounds to deteriorate.

Sources: Clinical records; home's policy "Wounds-statis ulcers, surgical and other wounds" (January 2011); interview with registered staff and ADOC.
[561]

This order must be complied with by June 16, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.