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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 12, 2016	2015_229213_0061	026266-15	Resident Quality Inspection

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive, Suite 305 TORONTO ON M9W 5Z9

Long-Term Care Home/Foyer de soins de longue durée

Henley Place
1961 Cedarhollow Boulevard LONDON ON N5X 0K2

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

RHONDA KUKOLY (213), AMIE GIBBS-WARD (630), CHRISTINE MCCARTHY (588), MELANIE NORTHEY (563), REBECCA DEWITTE (521)

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): December 15, 16, 17, 18, 21, 22, 2015

The following were completed concurrently within the Resident Quality Inspection (RQI):
Log #025377-15, an anonymous complaint related to water temperatures.
Log #025415-15, an anonymous complaint related to doors in the home.
Log #030826-15, a critical incident #3045-000050-15 related to a fall resulting in a significant change in condition.
Log #033824-15, an anonymous complaint regarding allegations of abuse.

Two complaints were completed by Inspector #569 while in the home during the RQI with separate reports:
Log #021426-15 Inspection #2015_326569_0027, related to air conditioning.
Log #022768-15 Inspection #2015_326569_0026, related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Associate Directors of Care, the Life Enrichment Manager, the Director of Behavioural Services, the Food Services Manager, four Registered Nurses (RN), one Registered Practical Nurse (RPN), seven Personal Support Workers (PSW), four family members, and over 40 residents.

The inspector(s) also toured the home, observed meal service, medication passes, medication storage areas and care provided to Residents, reviewed health records and plans of care for Residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **6 WN(s)**
- **3 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. 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Clinical record review revealed that resident #024 experienced weight loss in 2015.

Review of the electronic documentation for food and fluid intake record for a particular month in 2015, indicated that resident #024 had no food or fluid intake at a number of meals and snacks.

Interviews with personal support workers and registered staff indicated resident #024 was sleeping through meals and snacks on a regular basis. Interview with Registered Dietitian (RD) #125 identified there had been no dietary referral and resident #024 had not been assessed by the RD since the documented weight loss and reduced food and fluid intake.

Review of the home's "Nutrition Referral" policy #06-07, dated October 2013 revealed: "a referral to the Registered Dietitian should be made for": "residents for whom nutrition strategies and interventions have not been effective" and "residents deemed to be at risk in regards to nutrition and hydration status". Interview with RN #123 and RD #125 confirmed that a referral to the RD should have been made for resident #024 related to nutritional decline. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Medication cart narcotic bin observation revealed discontinued narcotics were stored in the locked narcotic bin in the medication cart, stored with narcotics for use that were both for standing order and those for PRN.

Staff interview with the Quality Assurance Nurse (QAN) #130 and a registered staff member confirmed discontinued narcotics for destruction were kept in the medication cart narcotic bin until pick up every Wednesday and confirmed they were stored with narcotics for use.

Record review of the "Narcotic Lock Box Policy Number: 3.19" effective August 1, 2011 revealed: "Narcotic and controlled prescriptions must be removed from the medication

cart upon discontinuation". "They must be safely transported to a secure area that is double locked". "Pursuant to a discontinuation order, the narcotic prescription (card, box, bottle, ampules, etc.) must be removed from the medication cart".

Record review of the "Discontinued Medication Orders Policy Number: 4.09" effective July 1, 2010 with a revision date of October 1, 2015 revealed: “Discontinued narcotics should not be stored with other discontinued medications. They must be kept in a secure area, away from medications that are being actively administered. This area is generally accessible only to the Director of Resident Care or Assistant Director of Nursing Care".

Staff interview with the Quality Assurance Nurse (QAN) #130 and the registered staff member confirmed discontinued narcotics for destruction were kept in the medication cart narcotic bin until pick up every Wednesday and confirmed they were stored with narcotics for use and this did not comply with their policy. [s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review of the "Environmental Services Policies and Procedures for “Laundry: Lost Clothing with an effective date of April 2010 and revised date of December 2014” revealed: "RPN/RN/Nurse Manager documents complaint on the missing laundry form found in the Lost Laundry Binder at each Nursing Station". "If laundry is not found in one (1) month the Administrator of the home will contact the resident/family to review situation further and initiate complaint form and document on complaint log".

Interview with a registered staff member confirmed the "Lost Laundry Binder" could not be located at the Nursing Station and suggested the binder was sent to the laundry room.

Staff interview with a laundry aide confirmed "Lost Items Only" cupboard did not contain any missing items for resident #048 or #046 and shared the "Lost Laundry Binder" never came to the laundry room as it was a reference binder used on the home care area only.

Interview with resident #046 confirmed the resident has had clothing missing on multiple occasions since admission. Resident #046 confirmed the most recent missing item was couple of weeks ago and shared they had told the nursing staff, but that there had been no follow-up at all and did not know what has happened.

Interview with resident #048 confirmed four particular items of clothing had gone missing

and shared that they did not want to send clothing down to laundry any more, worried they would be lost. Resident #048 also confirmed that the missing items were reported to the staff, but could not recall if a missing clothing form was completed and the resident had not heard back about any of the items or what was done to find them.

Staff interview with the Environmental Service Manager (ESM) #126 confirmed the process was that the nursing staff was to complete the Lost Clothing Report, the Associate Directors of Care (ADOCs) were to collect the forms daily and delivered them to the ESM office or his mailbox. The ESM confirmed if the item remained missing after a closet check by the nursing staff, waited for the laundry turn over, and after conversations with staff/residents; it was then to be forwarded to the Administrator for follow up. The ESM confirmed he did not recall a lost clothing form for resident #046 and #048.

Staff interview with the Administrator confirmed she did not receive lost clothing forms for missing clothing items for resident #046 and #048 and shared that the folder for missing clothing/laundry in her office did not have forms for resident #046 and #048 and that staff did not follow the home's policy. [s. 8. (1) (b)]

4. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review of the health record for resident #042 and a staff interview with a registered staff member revealed this resident had impaired skin integrity as of a particular date in 2015. Record review of the health record for resident #042 revealed no dietary referral related to impaired skin integrity and no dietary assessment related to the impaired skin integrity.

Record review of the policy "Wound Care Nutrition #06-18" dated October 2013 revealed: "Procedure #2. All residents who exhibit skin breakdown and/or wounds will be referred to the Registered Dietitian for a detailed nutritional assessment".

Staff interview with the Director of Care #102 confirmed the home's expectation that dietary referrals and assessments are completed in Point Click Care. She confirmed that the home's policy was not followed as staff did not complete a dietary referral for resident #042 related to impaired skin integrity and a nutritional/dietary assessment was not completed for resident #042 related to the impaired skin integrity identified in the resident's health record.[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 instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily.

Resident #024 was observed by Inspector #630 to receive no food or fluids at four particular meals/snacks as the resident was sleeping in bed.

Interviews with personal support workers and registered staff indicated resident #024 was sleeping through meals and snacks on a regular basis and their practice was to let this resident sleep. Interview with RN #123 confirmed that resident #024 did not consume lunch on an identified date and confirmed this resident had not had food or fluids at breakfast or am snack. They reported staff would give extra snacks in the afternoon. Interview with PSW #127 confirmed that resident #024 did not consume food or fluids at afternoon snack on that date. Interview with PSW #129 confirmed that resident #024 did not consume food or fluids at breakfast or lunch on another identified date.

Clinical record review and interviews with PSW #127, RN #123 and RD #125 confirmed there were no consistent interventions in place to provide specialized higher calorie snacks or tray service for resident #024 if meals or snacks were missed. RD #125 also confirmed there was no documented evidence of interventions for this nutritional risk of missed meals in the nutritional plan of care. [s. 71. (3) (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 each resident is offered a minimum of three meals daily, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of maintenance services there were schedules and procedures in place for routine, preventive and remedial maintenance.

Observations revealed the thermostat read 19 degrees Celsius, resident #024 was cold to touch. A staff member confirmed the thermostat read 19 degrees Celsius.

Observations two days later revealed the room thermostat read 20 degrees Celsius. A family member was present and voiced concern related to the room temperature. Resident #024 was cold to touch.

The Director of Care #102 was immediately informed on the first date and confirmed it was the home's expectation that the resident rooms were to be kept at a minimum temperature of 22 degrees Celsius.

Staff interview the Environmental Service Manager (ESM) #126 by Inspector #563, confirmed the air temperatures were taken twice daily in common areas but that there was no audit of resident rooms at any time. Interview with the Administrator #101 by Inspector #563, confirmed the home maintenance staff members did not monitor air temperatures in resident rooms as this was not part of the organized program of preventative maintenance services where there are schedules and procedures in place for routine, preventive and remedial maintenance. [s. 90. (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 as part of the organized program of maintenance services there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Observations of resident #014 on two occasions revealed two quarter bedside rails were in use. Interview with resident #014 confirmed the resident used two bedside rails while in bed and used the rails to assist with bed mobility.

Staff Interview with PSW #111 confirmed two side rails were used for bed mobility and another safety device with specific uses.

Record review of the current care plan indicated one quarter bed rail when in bed for transfers and bed mobility. Record review of the point of care tasks in the health record revealed one quarter bed rail for transfers and bed mobility. Another safety device in place was not documented in the tasks. Record review of the bed rail assessment in the health record indicated one bed rail up while in bed for bed mobility and transfer.

Staff interview with RPN #120 confirmed the current care plan identified the use of only one bedside rail and confirmed the plan of care did not have interventions in place regarding the other safety device. The RPN confirmed the tasks identified monitoring and documentation for only one bed rail and confirmed POC did not have monitoring or interventions related to the other safety device. The RPN confirmed the plan of care did not set out clear directions to staff and others who provided direct care to the resident related to the use of bedside rails and the other safety device. [s. 6. (1) (c)]

WN #5: 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:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the nutritional status, including height, weight and any risks relating to nutrition care with respect to the resident.

A family interview with a family member of resident #041 revealed the resident does not like the food and would not eat at one meal time daily. Staff interview with Registered Practical Nurse #124 revealed resident #041 refused to eat at one meal time on a daily basis.

Record review of the health record for resident #041 revealed the resident has a particular diagnosis affecting nutrition. Record review of the point of care tasks related to eating for resident #041 for the period of one month in 2015 revealed all of an identified meal time, except three were documented as refused. Record review of the assessments and referrals revealed that a dietary referral was completed very early in 2015 related to a family concern that the resident was skipping meals and the associated risks.

Record review the health record for resident #041 revealed no nutritional assessment related to this resident refusing/skipping meals. Record review of the plan of care revealed no documentation, goals or interventions related to resident #041 skipping meals and the associated risks.

Staff interview with the Director of Care #102 on December 22, 2015, confirmed the home's expectation that a dietary assessment should have been completed with goals and interventions identified for resident #041 related to skipping meals on a regular basis and the associated risks. [s. 26. (3) 13.]

WN #6: 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 :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration had been implemented.

Record review of the health record for resident #042 and a staff interview with Registered Practical Nurse #103 revealed this resident had impaired skin integrity.

Record review of the health record for resident #042 revealed no dietary referral related to impaired skin integrity and no dietary assessment related to the impaired skin integrity for a period of two months after it had been identified.

Staff interview with the Director of Care #102 confirmed that the home's expectation was that the staff should have completed a dietary referral and a nutritional assessment in Point Click Care when a resident was assessed as having impaired skin integrity. She confirmed that a dietary referral was not completed for resident #042 related to impaired skin integrity and a nutritional/dietary assessment was not completed for resident #042 related to impaired skin integrity ulcer for two months after it was identified. [s. 50. (2) (b) (iii)]

Issued on this 13th day of January, 2016

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

Original report signed by the inspector.