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 18, 2018	2018_674610_0005	005114-18	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

NATALIE MORONEY (610), HELENE DESABRAIS (615)

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 21, 22, 23, 26, 27, 28, and 29, 2018

The following Critical Incident System (CIS) report inspections were conducted concurrently during this inspection:
CIS #3045-000037-17/Log #000159-18 related to falls prevention and management
CIS #3045-000025-17/Log #021489-17 related to falls prevention and management
CIS #3045-000024-17/Log #021182-17 related to falls prevention and management

SAC 12530/3045-000021-16/Log #019390-16 allegation of resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Social Worker, Innovation of Quality Nurse, families and residents.

Inspector also observed medication rooms, resident care provision, resident and staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, relevant policies and procedures, meeting minutes, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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 :

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

Inspector had reviewed medication incidents that occurred in the home over a three month quarter in 2018. There were eight medication incident reports completed of those three were inspected upon:

Two specific residents were not administered a medication as prescribed as the medication had been omitted.

A specific Resident was administered a medication that was not prescribed and received the wrong medication.

The homes policy stated in Part: that Registered staff are not to sign for medication prior to giving them to the resident; the rule was to check one, pour one, sign for one was to be followed and practiced.

The Associate Director of Care said that they met and discussed the medication error for two specific residents with the nurses and that the registered staff explained that they were signing for the medication before the medication was administered.

Administrator said that they expected staff to administer and them to sign off after administering the medication and that medication would be administered to the residents as prescribed. [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 are 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 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.

During the resident quality inspection (RQI) the Inspector had reviewed current policies of the home and pharmacy service provider that were being utilized by the licensee, and documentation of drug administration, on the electronic Medication Administration Records e(MAR) and narcotic count sheets and individual narcotic sheets.

The licensee utilizes the pharmacy service provider Geriatrx pharmacy the policy titled Narcotics and Controlled Drugs #03.08-1 revised October 2015 stated in part that:

The nurse coming on duty will count together all of the narcotics and controlled substances, one nurse will physically count the drugs while the nurse going off duty will double check the records. Narcotic count sheets must be completed and signed by the

one nurse going off shift and the one nurse going on shift. Staff will record administration of the narcotic on the narcotic counting form as per the pharmacy policy and procedure.

A) The Inspector had completed observations of the controlled substance medication count, while two nurses completed the count verification record.

The observation showed that the individual narcotic controlled count sheet for a specific resident was not correct and that the resident had been administered a controlled substance and that staff did not document the administration on the individual narcotic form. The count records of the medication were not accurately counted for, or signed for in 21 days.

The "Monthly Narcotic Audit" that had been completed for an identified home area, showed that the resident's unit count and individual count and amount on hand was documented as completed and marked as no discrepancies.

B) Another identified home area, unit narcotic count records showed that the documentation for the narcotic shift counts did not include signatures by two registered staff for every shift for five identified days.

During an interview on the DOC and the Administrator told the inspectors that the licensee's expectation was that two registered staff would sign off on each shift when completing the narcotic shift counts and the Administrator said they expected that staff would sign off at the time of giving the medication on the controlled substance sheet.

The registered staff have failed to complete the signage on the Controlled Substance Shift Count sheets and the individual Controlled Narcotic Count sheets for the administered medication of residents.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. [s. 8. (1) (b)]

Issued on this 4th day of June, 2018

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

Original report signed by the inspector.