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
Jun 4, 2015	2015_226192_0037	003274-15	Complaint

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

DEBORA SAVILLE (192)

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): June 2 and 3, 2015

This complaint inspection related to the provision of personal hygiene and bathing, nutrition and hydration was completed concurrently with complaint inspection log number 003570-15

During the course of the inspection, the inspector(s) spoke with the Director of Care, Assistant Director of Care, Registered Practical Nurse, Personal Support Workers and residents.

The inspector reviewed medical records, policy and procedure, and observed meal and tray service.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 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 has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care under Nutrition Status and the Medication Administration Record for resident #001 stated that the resident was to be provided a supplement daily following a meal.

Interview with the Substitute Decision Maker (SDM) and observation confirmed that the resident was provided the supplement prior to the meal.

Interview with the Registered Practical Nurse confirmed that the supplement was provided to the resident at the time designated in the Medication Administration Record and that when the resident refused to come to the Dining Room, the supplement was provided.

Interview with the resident identified that they had taken the supplement and did not feel like having the meal.

The licensee failed to ensure that resident #001 was provided a supplement as ordered by the Registered Dietitian.[s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident #001 was identified in interview and record review to receive less than two baths weekly.

Record review identified that resident #001 received four of nine scheduled baths in May 2015. For two specified weeks in May 2015 resident #001 received no bath. Records indicate that the resident refused bathing on the remaining scheduled dates, however interview and record review confirmed that bathing was not offered on an alternate day of the week if the resident refused on the scheduled day.

The licensee failed to ensure that resident #001 was bathed, at a minimum, twice a week during May 2015. [s. 33. (1)]

Issued on this 18th day of June, 2015

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

Original report signed by the inspector.