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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 29, 2017	2017_263524_0012	009052-17	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

INA REYNOLDS (524), ALI NASSER (523), MARIAN MACDONALD (137)

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): May 15, 16, 17, 18, 23, 24, 25, 26, 2017.

The following intakes were completed within the RQI:
Complaints:
Log # 023777-16 / IL-45951-LO related to responsive behaviours
Log # 024358-16 / IL-45886-LO related to sufficient staffing
Log # 026542-16 / IL-46361-LO related to personal support services

Critical Incidents:
Log # 010780-16 / CIR 3045-000010-16 related to responsive behaviours
Log # 019706-16 / CIR 3045-000022-16 related to hospitalization and change in condition
Log # 028166-16 / CIR 3045-000029-16 related to allegations of abuse
Log # 032240-16 / CIR 3045-000033-16 related to falls prevention
Log # 032274-16 / CIR 3045-000034-16 related to falls prevention
Log # 032424-16 / CIR 3045-000035-16 related to allegations of abuse
Log # 033914-16 / CIR 3045-000040-16 related to falls prevention
Log # 034349-16 / CIR 3045-000042-16 related to falls prevention
Log # 002129-17 / CIR 3045-000002-17 related to personal support services
Log # 008992-17 / CIR 3045-000013-17 related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Clinical Services, the Director of Care, two Associate Directors of Care, the Life Enrichment Coordinator, the Environmental Operation Manager, one Environmental Services Assistant, two Registered Nurses, 12 Registered Practical Nurses, 17 Personal Support Workers, one Dietary Aide, one Physiotherapy Assistant, one Resident Council Representative, one Family Council Representative, family members and residents.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, dining services, medication administration, a medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, internal investigation notes, relevant policies and procedures of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
Sufficient Staffing

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	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 the care set out in the plan of care was provided to the resident as specified in the plan.

A review of a Critical Incident System (CIS) report submitted by the home on an specific date, showed that an identified resident was placed on personal assistive services device (PASD) and left unattended. The resident attempted to get off the PASD by themselves and had a fall, no injuries resulted from the fall.

A review of the plan of care showed that Personal Support Worker (PSW) staff were to monitor the resident closely and ensure that staff stayed with the resident throughout the identified care process.

The Administrator acknowledged in an interview that the resident's plan of care directed staff to stay with the resident when the resident was on the PASD and not to be left alone. The Administrator acknowledged that staff assisted resident on this occasion and left them on the PASD unattended and that the care was not provided to the resident as specified in the plan of care.

The Administrator said that it was the home's expectation that the care set out in the plan of care would be provided to the resident as specified in the plan. [s. 6. (7)]

2. A Critical Incident System (CIS) report was submitted by the home on a specific date, related to an incident where an identified resident was being provided a personal care activity at a specific time and left unattended until found at a later time, by a Personal Support Worker (PSW) from a different home area. There were no injuries sustained and there was no negative outcome to the resident.

A clinical record review of the plan of care showed two staff members were to follow specific directions when providing this personal care activity. Staff were to stay with the resident to ensure the resident's safety.

During interviews on May 26, 2017, two PSW's said that the directions identified in the plan of care was the care the resident required.

During an interview on May 26, 2017, the Administrator said that the directions identified in the plan of care was the care the resident required and that the care set out in the plan of care was not provided to the resident as specified in the plan.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had related non-compliance in the last three years. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A review of a Critical Incident System (CIS) report submitted by the home, showed that on a specific date, an identified resident informed a registered staff member of an alleged resident to resident abuse.

A clinical record review for the identified resident showed a progress note on a specific date and time, that the resident reported alleged abuse and that the behaviours of another resident made them uncomfortable and had tried to abuse them a few times. Registered staff member informed a Registered Nurse (RN).

The RN said in an interview that they were informed of the alleged resident to resident abuse and that they did not inform the manager on call on that day. They informed the on call manager the day after.

The Administrator and Director of Care (DOC) said in an interview that the expectation

was for the RN to immediately report to the on call manager the allegations of abuse. They acknowledged that the RN did not inform the on call manager of the allegations of resident to resident abuse until the next day.

A review with the the Director of Clinical Services and DOC of the home’s policy "Zero Tolerance of Resident Abuse/Neglect", policy number 02-17 revision date September 2013, showed it stated under the procedure that “in case of any abuse/neglect or suspected abuse, the employee, student, volunteer or any other person witnessing or having knowledge of an incident shall, immediately report the incident to their department manager, immediate supervisor or during off hours, the most senior supervisor available".

The Director of Clinical Services and DOC acknowledged in an interview that the identified RN did not comply with the home’s policy by not reporting to the on call manager immediately the allegation of resident to resident abuse.

The Administrator, Director of Clinical Services and DOC said that the expectation was for the RN to call the on call manager and inform them of the allegations.

The scope of this area of non-compliance was isolated and the severity was determined to be potential for risk. The home had unrelated non-compliance in the last three years. [s. 20. (1)]

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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

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Issued on this 13th day of July, 2017

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

Original report signed by the inspector.