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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 29, 2019	2019_788721_0012	004580-19, 005544-19	Critical Incident System

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

MEAGAN MCGREGOR (721), KRISTEN MURRAY (731)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 12, 2019.

The following Critical Incident (CI) reports were inspected during the course of this inspection:

CI #3045-000008-19/Log #005544-19 related to falls prevention and management;
CI #3045-000006-19/Log #004580-19 related to falls prevention and management.

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

The inspectors also observed residents and the care provided to them, reviewed clinical records and plans of care for identified residents and reviewed documentation related to the home's Falls Prevention and Management program.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

- **1 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	Légende 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding a transfer to hospital of resident #002, following complaints of pain, which identified a fracture.

In an interview with resident #002, when asked how the resident got around the home, the resident stated in a wheelchair. When asked how the resident got around the home prior to sustaining their fracture, the resident stated they had previously gotten around the home with a walker.

In a clinical record review for resident #002 on a specific date, the care plan for resident #002 indicated that the resident was to receive set-up help with their walker, supervision and verbal cueing for resident #002 to walk with their walker. A review of the clinical record for resident #002 did not identify the use of a wheelchair following resident #002's return from hospital.

In an interview with a Personal Support Worker (PSW), when asked where they would look for information about a resident's transfer and mobility status, the PSW stated they would look in the resident's care plan, Kardex and inside the closet door in their room. When asked what resident #002's current mobility status was, the PSW stated that they ambulated with a wheelchair. When asked where they would find the resident's current mobility status, the PSW stated this would be in the Kardex and that resident #002's Kardex only identified the use of a walker.

In an interview with a Registered Practical Nurse (RPN), when asked where they would look for information about a resident's transfer and mobility status, the RPN stated that they would look in the resident's care plan and at the logos in the resident's room. When asked what resident #002's current mobility status was, the RPN stated that after returning from hospital resident #002 used a wheelchair. When asked how they would know if a resident used a wheelchair, the RPN stated this would be in their care plan and that it was not in the care plan for resident #002.

In an interview with the Director of Care (DOC), when asked what resident #002's

mobility status was prior to and upon returning from the hospital, the DOC stated that they used a walker before the fracture and had used a wheelchair since they sustained the fracture. When asked if resident #002's care plan was updated to reflect their change in mobility status after they returned from hospital, the DOC stated that it was it was not. When asked if it was the home's expectation that resident #002's care plan should have been updated upon their return from hospital when their mobility status changed and they required the use of a wheelchair for ambulation, the DOC stated it was.

The licensee failed to ensure that the plan of care for resident #002 was reviewed and revised when the resident's care needs changed and care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.