Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 27, 2019	2019_788721_0042	017798-19, 019241-19	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

MEAGAN MCGREGOR (721), CASSANDRA ALEKSIC (689)

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): November 12, 13, 14, 15 and 20, 2019.

The following Complaint intakes were completed within this inspection:

Log #017798-19 related to dining service concerns; and
Log #019241-19 related to resident's bill of rights concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Associate Directors of Care, the Assistant Manager of Informatics, the Business Manager, a Social Worker, a Receptionist, a Registered Nurse, two Registered Practical Nurses, four Personal Support Workers, residents and visitors.

The Inspectors also observed residents and the care provided to them, reviewed clinical records and plans of care for the identified residents and reviewed the homes documentation related to the complaints.

This inspection was conducted concurrently with Critical Incident System Inspection #2019_788721_0040 and Follow-up Inspection #2019_788721_0041.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

A) The Ministry of Long-Term Care (MOLTC) received a complaint which included concerns related to Resident's Bill of Rights for resident #005.

Resident #005's Progress Notes in Point Click Care (PCC) were reviewed and showed the following:
- Note from a specific date, stated the resident had a specific list of people who may visit them and that no other visitors were allowed unless authorized by their Power of Attorney (POA). The note stated that specific visitors entered the home and greeted resident #005 by name. The writer asked the visitors for their names and as per the visitor list provided from the POA, their names were not listed. In a subsequent note, the writer stated that the visitors were not approved to visit the resident and they were asked to leave with the Associate Director of Care's (ADOC) support.
- Note from a specific date, stated that specific visitors had arrived to see resident #005 and the home was previously advised that the visitors were people that could not visit the resident. The Receptionist advised the visitors that they could not visit the resident as per direction from the POA.

On a specific date, Receptionist #103 stated that they would document information provided from the POA in PCC under the Profile section. Receptionist #103 stated that resident #005's POA did not want certain people to visit and resident #005 could only have visitors who were on the list provided by the POA. The Receptionist said that the POA had requested the visitors mentioned in the identified progress notes were not to visit the resident and they were asked to leave the home on the date of one of the identified progress notes.

Resident #005's Profile section in PCC was reviewed and under the POA comments section stated only specific visitors listed on the profile were allowed to visit the resident. The names of the visitors indicated in the identified progress notes were not documented on this list.

On a specific date, ADOC #104 said that they were involved with the event regarding resident #005's visitor access on one of the dates identified in resident #005's progress

notes, at which time they were the Administrator of the home. The ADOC said that the documented visitor list was in response to a letter that was received from resident #005's POA which identified a list of people that could visit the resident. The ADOC stated that on the identified date, they spoke with the visitors and told them that they had received instructions from the resident's POA that they had to comply with. ADOC #104 said that the resident was able to understand simple direction related to decisions regarding their care needs. When asked if resident #005 was communicated with regarding their wishes for visitors, the ADOC stated that they were unsure.

On a specific date, Registered Nurse (RN) #109 stated that POA documentation would be completed by a resident's family and brought into the home on admission. The RN said that the Business Manager and Social Worker (SW) were responsible for gathering information on resident consent and capacity. RN #109 stated that capacity was determined through a Mini Mental State Examination (MMSE) assessment and that this was completed by the SW. The RN said that a resident's capacity to make decisions was based on MMSE, on the residents Cognitive Performance Scale (CPS) scores and the Local Health Integration Network (LHIN) determination of capacity prior to entry into the home.

The LHIN referral for resident #005 was reviewed and documented that they were capable of making long-term care admission decisions.

On a specific date, SW #115 stated that a resident's capacity to make decisions was determined by completing the MMSE assessment which was completed on admission and documented in PCC. When asked how capacity was determined if there was no MMSE completed for resident #005, the SW said that was problematic and their capacity should have been determined. The SW stated that they were not working in the home at the time of the incident and that the MMSE assessment may have been missed for resident #005 when they were admitted to the home.

There were no MMSE assessments or capacity assessments documented in resident #005's clinical records.

On a specific date, ADOC #112 stated that capacity was determined based on information retrieved prior to admission from the LHIN and through a capacity assessment completed in the home. ADOC #112 said that a resident's POA for personal care could make decisions regarding their advance care directives, medications, hospital visits or anything to do with their well-being. When asked if resident #005 was capable

and had capacity to make decisions, the ADOC stated yes. When asked if the resident should have the right to communicate who they would like as a visitor, the ADOC stated yes and they expected that the resident should have been asked what their wishes were.

B) During the inspection Inspector #689 was informed that resident #007 had a list of people who could or could not visit them.

Resident #007's Progress Notes in PCC were reviewed and showed the following:
- Note from a specific date, stated that the resident had specific visitors that were listed on their profile as being allowed to come into the home. A staff member called the resident's POA to ask if they would like the visitors removed and the POA directed them to have a specific visitor removed. The note stated that the writer went to ask the visitor to leave, however, had already left.

Resident #007's Profile section in PCC was reviewed and under the POA comments section stated that only specific visitors listed on the profile were allowed to visit the resident and that staff were to notify the POA and monitor the visit when specific visitors visited. The names of the visitors indicated in the identified progress notes were included as part of the specific list of visitors that were allowed to visit the resident and who staff were to notify the POA and monitor the residents visit with.

On a specific date, Inspector #689 observed resident #007 with specific visitors in a common area of the home. The visitors stated that they had been visiting the resident for a specific length of time and that they were denied entry and not allowed to visit the resident in the home prior to this. When asked if the resident had reached out to them, the visitors said that resident #007 called them around the time of their admission. The visitors stated that after they were permitted to visit, they were not allowed to see resident #007 in private and had to stay in a common area where staff could monitor the visit.

On a specific date, ADOC #112 stated that they were familiar with the event on the date identified in resident #007's progress notes where resident #007's specific visitors were asked to leave by the home based on discussion with their POA. When asked if the home was concerned for the resident or their safety, the ADOC said no. ADOC #112 said that they were unsure if there was communication between the home and the resident to determine their wishes to have visitors and they expected that there should have been.

On a specific date, Administrator #100 stated that they were familiar with resident #007's

visitor list which was implemented by their POA. When asked if they knew of any instance where the resident's visitors were asked to leave, the Administrator said they were not aware. Administrator #100 said that they would expect that the resident would have been communicated with to determine their wishes for visitors. Inspector #689 informed the Administrator that the visitors stated that they could not meet with resident #007 privately. The Administrator stated that they were not concerned for resident #007's safety and expected that they would have been given the right to receive visitors of their choice and consult in private without interference.

The licensee has failed to ensure that the rights of resident #005 and #007 were fully respected and promoted, including the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference. [s. 3. (1) 14.]

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 every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference, to be implemented voluntarily.

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.