Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 3, 2020	2019_788721_0048	023072-19, 023174-19, 023387-19, 023622-19	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)

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): December 16, 17 and 18, 2019.

The following Complaint and Critical Incident (CI) intakes were completed within this inspection:

Log #023174-19/ACTIONline #IL-72666-LO related to allegations of resident neglect;
Log #023072-19/CI #3045-000048-19 related to allegations of resident neglect;
Log #023387-19/CI #3045-000049-19 related to allegations of resident abuse; and
Log #023622-19/CI #3045-000050-19 related to allegations of resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), an Associate Director of Care (ADOC), the Programs Manager, the Environmental Services Manager (ESM), three Registered Practical Nurses (RPNs), three Personal Support Workers (PSWs), a housekeeping staff member, residents and visitors.

The Inspector also observed residents and the care provided to them, reviewed clinical records and plans of care for the identified residents and reviewed the home's investigation notes and policies relevant to the incidents.

This inspection was conducted concurrently with Follow-up Inspection #2019_788721_0047.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and ensure that residents were not neglected by staff.

A) The Ministry of Long-Term Care (MOLTC) received a complaint which included concerns related to an incident where staff left resident #002 unattended in their washroom for approximately an hour and a half on a specific date. The complainant reported that the call bell in resident #002's washroom was not functioning during this time period and resident #002 was found in their washroom calling for help by resident #003. The home also submitted a Critical Incident System (CIS) report to the MOLTC related to this incident. The CIS report stated that resident #002 was taken to the washroom and provided care by staff at a specific time and staff returned to finish providing the care approximately an hour and a half later. During this time resident #002's call bell was not functioning properly. A PSW staff member reported that they checked on resident #002 approximately 15 minutes after they had been taken to their washroom, at which time resident #002 was not ready for staff to finish providing the required care, and then they forgot to go back to check on them.

A review of the Primacare policy titled "Zero Tolerance of Resident Abuse/Neglect", Policy Number: 02-17, Date of Origin: July 2010, Revision Date: September 2013, stated in part the following:
- Primacare is committed to promoting an abuse/neglect free environment for all residents in their care and enforces a zero tolerance policy at all times.
- Definition of Abuse: Abuse has been defined as any act, committed or omitted, that results in harm to or jeopardizes the well-being or safety of another person.
- Physical Abuse: Any act of unwanted physical and/or sexual contact. Any act of violence or rough treatment. Includes: rough handling, administering a treatment roughly, pushing or shoving. Indicators: Any unusual pattern or location of injury such as clustered bruises or welts, or bruising along the inner arm or thigh, or any other soft body parts such as abdomen, buttocks. Unexplained injuries or behavioural changes.
- Neglect Active/Passive: Withholding any basic needs for life. Refusal or failure to fulfill a job related duty/function. Includes: Refusing to provide assistance to bathroom when resident requests or requires such assistance. Unreasonably ignoring calls for assistance. Lack of necessary safety precautions to prevent injury to resident.

A review of resident #002's Care Plan section in PointClickCare (PCC) from the specific date of the incident indicated that resident #002 required staff assistance with care, as

needed. It was also indicated that resident #002 was at risk for falls and that comfort rounds at specific time intervals to ensure safety and having a call bell within reach were to be in place as interventions related to falls prevention.

A review of resident #002's Progress Notes in PCC documented that an hour and a half after the time that resident #002 was taken to their washroom resident #003 came to the nursing station and stated to the nurse that resident #002 was upset as they were left without care over a long period of time. At this time the nurse went to check on resident #002 and the resident was upset and reported pain.

During an interview on a specific date, when asked what kind of care they required related to using the washroom, resident #002 said they required staff assistance with specific care and that they would use their call bell to let staff know when they needed help with this care. When asked if they recalled a time where they waited a long time for staff to come provide this care, resident #002 said they sometimes had to wait awhile and when they had to wait a long time it made them feel very anxious. Resident #003 was also present during this interview and both residents recalled the identified incident on a specific date, where resident #002 was left in their washroom without care for approximately an hour and a half. Resident #003 said that at the time when they found resident #002 in their washroom, they could hear staff in the hallway outside of resident #002's room while resident #002 called for help.

During an interview on a specific date, when asked how they would know what interventions were in place for a resident related to falls prevention, PSW #108 said it would be indicated in their care plan. PSW #108 stated that resident #002 was at risk of falling and required frequent checks as an intervention to reduce their risk of falls. When asked where they would document that these checks were completed, PSW #108 stated there was a scheduled task for checks at specific time intervals in PointofCare (POC) and it would be documented there. When asked about the incident on a specific date, where resident #002 was left in their washroom without care for approximately an hour and a half, PSW #108 said that they were working a specific shift on that date and that resident #002 was taken to their washroom by staff on the previous shift. PSW #108 stated that resident #002 was already in their washroom at shift change and the oncoming staff didn't know they were there. PSW #108 said that staff should report if a resident was in the washroom at shift change and that on this date it was not reported at shift change that resident #002 was in their washroom. PSW #108 stated they were made aware resident #002 was in their washroom when resident #003 brought it to their attention. PSW #108 stated that resident #002 was upset when staff found them and at

that time staff realized the call bell wasn't working. When asked if scheduled checks at specific time intervals were completed during the identified time period when resident #002 was in the washroom, PSW #108 was unable to recall.

A review of a report titled "Documentation Survey Report v2" from POC for resident #002 showed a task for intentional comfort rounds related to falls prevention that were scheduled at specific time intervals during the time period that resident #002 was identified to have been left in their washroom on the identified date.

A review of the home's investigation notes showed the following related to the incident:
- A written statement from PSW #111 stated that on the identified date of the incident they saw resident #002 in their washroom at a specific time and asked if they were ready for staff to assist with providing care and resident #002 replied no. At this time PSW #111 left resident #002 in their washroom and continued providing care to other residents until approximately one hour later when another staff member notified them that resident #002 needed help. At a specific time which was approximately an hour and a half after resident #002 was taken to the washroom, PSW #111 went to finish providing care for resident #002 in their washroom.
- A written statement from PSW #108 stated that on on the identified date of the incident they attended shift report at the start of their shift and then provided care to other residents until approximately one hour later when PSW #111 asked for help with providing care to resident #002.
- An email from Administrator #100 addressed to resident #002's Power of Attorney (POA) regarding the incident stated that the home reviewed video footage from the date of the incident and validated that PSW #111 entered resident #002's room at a specific time and did not return until over an hour later.

During an interview on a specific date Administrator #100 reviewed resident #002's clinical record and the CIS report with Inspector #721. When asked if intentional comfort rounds were completed at specific time intervals as indicated in resident #002's plan of care between the specific time when they were taken to the washroom and the specific time when staff returned to finish providing care on the date of the incident, Administrator #100 said that review of camera footage validated they were not completed. When asked if they expected that intentional comfort rounds should have been completed at specific time intervals for resident #002 during the identified time when they were left in their washroom without care, Administrator #100 said they would. When asked if they considered staff not checking on resident #002 and leaving them in their washroom without care for approximately an hour and half to be neglect, Administrator #100 said

they did.

B) On a specific date the home submitted a CIS report to the MOLTC related to allegations of physical abuse by a staff member towards resident #005, resulting in altered skin integrity.

A review of resident #005's Progress Notes in PCC showed the following:
- An note from a specific date and time stated that staff found specific areas of altered skin integrity of unknown cause on resident #005. At this time resident #005 denied falling or hitting anything.
- An Administration/DOC Note from a specific date and time stated that ADOC #106 and ADOC #107 spoke with resident #005 regarding a comment resident #005 made to staff about staff on a specific shift being rough with them. Resident #005 reported to the ADOC's that staff on a specific shift rushed them during care and did not give them a chance to participate in care.
- A Physician's Note from a specific date and time stated that resident #005 had a specific area of altered skin integrity and the resident stated staff were rough when providing care on a specific shift.

A review of a report titled "Documentation Survey Report v2" from POC for resident #005 showed a task for intentional comfort rounds scheduled at specific time intervals. This task was documented as completed by PSW #114 at the specific dates and times that resident #005 had identified a staff member was rough with them during care.

A review of the home's investigation notes showed the following related to the incident:
- A written statement from PSW #115 and PSW #116 stated that they were made aware of the areas of altered skin integrity of unknown cause on resident #005 on a specific date. On this specific date PSW #115 asked resident #005 how they acquired one of the areas of altered skin integrity and resident #005 stated it was from PSW #114 being rough with them. PSW #116 later went in to see resident #005 and asked how they acquired one of the areas of altered skin integrity and resident #005 stated PSW #114 was rough and threw them around, not giving them the chance to help with care.
- Photos taken by ADOC #107 on a specific date two days after the areas of altered skin integrity were first identified which showed significant skin alteration in a specific location on resident #005.
- A statement written by ADOC #107 stated that they witnessed a conversation between ADOC #106 and resident #005 on a specific date and resident #005 said a staff member on a specific shift rushed them during care and did not give them a chance to participate

in care.
- Employee Investigation Form from a specific date documented an interview with PSW #115 who worked the specific shift identified by resident #005. PSW #115 stated that PSW #114 provided specific care to resident #005 at specific times on this shift.
- Employee Investigation Form from a specific date documented an interview with PSW #114 who stated that they had provided specific care to resident #005 at specific times on the specific shift identified by resident #005. A written statement was attached to this investigation form which stated that on a specific date police came in to review camera footage and observed PSW #114 had responded to resident #005's call bell on the specific shift identified by resident #005. DOC #101 was informed by police that PSW #114 was being charged with assault related to the incident and was no longer allowed to be near resident #005 or on the premises of the home.
- Documentation from a meeting between Administrator #100, ADOC #106 and resident #005 on a specific date in which resident #005 stated PSW #114 provided specific care for them on a specific shift and described the care provided as being rough and rushed.

A review of the MOLTC CI reporting system showed that the home previously submitted a CIS report on a specific date related to allegations that PSW #114 physically abused another resident. As a result of these allegations, PSW #114 was transferred to work in another home area, received counseling and was required to review the home's abuse policy.

During an interview on a specific date Administrator #100 reviewed resident #005's clinical record and the CIS report with Inspector #721. Administrator #100 stated that review of camera footage and interviews with staff and resident #005 validated that PSW #114 had provided specific care to resident #005 on the specific shift identified by resident #005 and was the staff member alleged to have been rough during care causing resident #005's areas of altered skin integrity. Administrator #100 stated that police also conducted an investigation and PSW #114 was charged with assault as a result of this investigation and was no longer allowed at the home or near resident #005. Administrator #100 said that when they interviewed PSW #114 the PSW denied being rough during care with resident #005, but that they believed resident #005 that PSW #114 was rough during care and were not okay with it. Administrator #100 stated that following the investigation, PSW #114 was terminated based on the outcome of the police investigation and previous allegations of abuse involving PSW #114.

The licensee failed to protect resident #002 from neglect and resident #005 from abuse by staff. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 3rd day of January, 2020

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

Original report signed by the inspector.