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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 11, 2022	2022_917213_0005 (A2)	012981-21, 012982-21, 012983-21, 012988-21, 016639-21, 016810-21, 017560-21, 017912-21, 018109-21, 018215-21, 018399-21, 019472-21, 019473-21, 019474-21, 019475-21, 019476-21, 000834-22, 001616-22	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

Amended by RHONDA KUKOLY (213) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The Executive Director requested a two week extension of the compliance due dates. Compliance Orders #001, #002 and #004 have been extended from April 14, 2022, to April 28, 2022. Compliance Orders #005, #006 and #007 have been extended from May 13, 2022, to May 27, 2022, and the date for submitting the compliance plans for these orders has been extended from April 14, 2022, to April 28, 2022.

Issued on this 11st day of April, 2022 (A2)

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

Original report signed by the inspector.

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1961 Cedarhollow Boulevard London ON N5X 0K2

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

Amended by RHONDA KUKOLY (213) - (A2)

Amended 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): February 17, 18, 22, 23, 24, 25, 28, March 1, 2, 3, 4, 6, 8, 2022.

The following intakes were completed during this critical incident inspection:

Log #012981-21, a follow-up to compliance order #001 from inspection #2021_605213_0018, related to care plans regarding the use of footrests being based on an assessment of the resident

Log #012982-21, a follow-up to compliance order #005 from inspection #2021_605213_0018, related to infection prevention and control and resident hand hygiene

Log #012983-21, a follow-up to compliance order #004 from inspection #2021_605213_0018, related to vaccination of residents

Log #012988-21, a follow-up to compliance order #007 from inspection #2021_605213_0018, related to reporting to the Director

Log #016639-21, critical incident #3045-000099-21, related to a resident being served the wrong diet texture

Log #016810-21, critical incident #3045-000103-21, related to alleged neglect

Log #017560-21, critical incident #3045-000112-21, related to alleged neglect

Log #017912-21, critical incident #3045-000116-21, related to a missing controlled substance

Log #018109-21, critical incident #3045-000118-21, related to alleged neglect

Log #018215-21, critical incident 3045-000121-21, related to errors in administering/documentation of influenza vaccines

Log #018399-21, critical incident #000122-21, related to alleged neglect

Log #019472-21, a follow-up to compliance order #001 from inspection #2021_928577_0002, related to complying with the home's medication policies

Log #019473-21, a follow-up to compliance order #002 from inspection #2021_928577_0002, related to critical incident response

Log #019474-21, a follow-up to compliance order #001 from inspection #2021_928577_0003, related to clear direction in the plan of care regarding the use of oxygen

Log #019475-21, a follow-up to compliance order #002 from inspection #2021_928577_0003, related to medication administration

Log #019476-21, a follow-up to compliance order #003 from inspection #2021_928577_0003, related to medication incidents

Log #000834-22, critical incident #3045-000001-22, related to alleged abuse

Log #001616-22, critical incident #3045-000005-22, related to alleged abuse

This inspection was completed while concurrently completing complaint inspection #2022_917213_0006.

During the course of the inspection, the inspector(s) spoke with the Vice President of Primacare Living, the Executive Director, the Acting Director of

Care, two Associate Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Housekeeper, residents and families.

The inspectors also made observations and reviewed health records, communications in the home, policies and procedures, internal investigation records and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

- **10 WN(s)**
- **2 VPC(s)**
- **7 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 107. (4)	CO #002	2021_928577_0002	213
O.Reg 79/10 s. 135.	CO #003	2021_928577_0003	213
O.Reg 79/10 s. 229. (4)	CO #005	2021_605213_0018	213
O.Reg 79/10 s. 8. (1)	CO #001	2021_928577_0002	213

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that a registered nursing staff member administered drugs to 23 residents as specified by the prescriber.

A registered nursing staff member administered morning medications to 23 residents two to three hours past the time for administration identified in the electronic Medication Administration Record (eMAR) and physicians' orders. Some of these late medications were high risk medications, including narcotics, psychotropics, and insulin. One resident complained that the delayed administration of their scheduled narcotic caused them to have pain. An Associate Director of Care (DOC) said that they were not aware of the late medication administration and that their expectation was that medications were administered on time as prescribed.

Sources: Observations of medication administration, residents' eMARs and progress notes, and staff interviews. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).
2. Residents must be offered immunization against influenza at the appropriate time each year. O. Reg. 79/10, s. 229 (10).
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered immunization against influenza, pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

All residents were not offered immunization against influenza, pneumococcus, tetanus and diphtheria, in accordance with the publicly funded immunization schedules, putting them at risk for infection. The Acting DOC and an Associate DOC said that all vaccinations were put on hold after an error in documentation of influenza vaccination occurred, as well as a significant covid-19 outbreak.

Sources: Audit of vaccinations and TB screening, health records and staff interviews. [s. 229. (10)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for two residents provided clear direction to staff and others who provide direct care to the residents.

Two residents had unclear and conflicting direction in their plans of care and both had no direction in Point of Care (POC) for Personal Support Workers (PSWs) for a special need. Associate DOCs said the care plans did not provide clear direction and that there should have been direction in POC for PSWs. Two residents were at risk of care not being provided properly when the plans of care did not provide clear direction.

Sources: Observations of and health records for two residents, and staff interviews. [s. 6. (1) (c)]

2. The licensee has failed to ensure that care set out in the plan of care for residents was based on assessments of the residents and the needs and preferences of the residents.

Direction in the plans of care for five residents did not match assessments completed. This put residents at risk for injury. The Acting DOC and an Associate DOC said that the care plans for a number of residents were not based on assessments completed, and that the expectation was that the direction in the care plan matched the assessment.

Sources: Observations of residents and resident health records, and staff interviews. [s. 6. (2)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 004

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members who suspected abuse and neglect of residents that resulted in risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director.

There were three reports of alleged abuse and/or neglect reported by staff members to the management of the home. They were reported days after the alleged incidents. Residents were put at continued risk of abuse and neglect when staff did not report alleged abuse immediately.

Sources: Three CIS reports, investigative documentation, witness statements, and staff interviews. [s. 24. (1)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005

WN #5: 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 and/or neglect.

O. Reg 79/10 defines abuse as follows:
- Emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident
- Physical abuse means, subject to the use of physical force by anyone other than a resident that causes physical injury or pain
- Verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident

The home notified the Ministry of Long-Term Care of a report of alleged abuse of residents. Witness statements, the home's investigation notes, interviews with staff and management of the home verified that the alleged abuse did occur.

Sources: CIS report, resident clinical records, the investigation documentation, and staff interviews. [s. 19. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 006

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that alleged incidents of abuse of residents that were reported to the licensee, were immediately investigated, and appropriate action was taken in response, including that the residents' substitute decision-maker (SDM), if any, were notified immediately.

a) The home notified the Ministry of Long-Term Care of a report of alleged abuse of residents. However, six other residents were also identified during the investigation. The Acting DOC verified the alleged incidents of abuse of the six other residents were not immediately investigated, and the appropriate action was not taken, including interviewing and assessing the residents, and notifying SDMs. (563)

b) The home's management team were notified of an allegation of abuse of a resident. The investigation was not completed immediately, and appropriate actions not taken until over a month later, and the resident's SDM was not notified

of the alleged abuse. The Acting DOC acknowledged that the investigation should have been completed immediately with appropriate actions taken, and the resident's SDM should have been notified. (721442)

Residents were put at further risk of harm when the alleged incidents of abuse of residents were not investigated, and appropriate actions were not taken.

Sources: CIS reports, resident clinical records, the investigation documentation, the Primacare Policy Number 06-02: Zero Tolerance of Resident Abuse/Neglect, and staff interviews. [s. 23. (1)]

2. The licensee has failed to ensure that the results of the investigation for three CIS reports, related to suspected abuse and neglect, were reported to the Director.

The home notified the Ministry of Long-Term Care of three reports of alleged abuse of residents. All of the reports indicated the home would update the report with the results of the investigation once completed, but were never updated. Management of the home said that the reports were not amended to include the results of the investigation and should have been. A documented investigative conclusion as part of the report to the Director would have verified there was follow up by the home in the prevention of abuse and neglect of residents.

Sources: CIS reports, email correspondence, investigative documentation, and staff interviews. [s. 23. (2)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 007

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 results of investigations related to suspected abuse and neglect are reported to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date received, action taken, final resolution, and dates responses were provided to complainants. The licensee also failed to ensure the documented record of complaints was reviewed and analyzed for trends at least quarterly, the results of the review and analysis taken into account in determining what improvements were required and a written record kept of the review and improvements made in response.

Five CIS reports were reported by the home to the Ministry of Long-Term Care. All five of the CIS reported complaints related to care of residents and did not include documentation of these complaints, action taken to resolve the complaint, date of the action, time frames for actions to be taken, any follow-up action required, the final resolution, the date response was provided to the complainant, or any response made in turn by the complainant.

The Executive Director (ED) said that there was no documented record of the complaints identified in the critical incident reports. There was one documented quarterly review and analysis of documented complaints for Quarter 4 in 2021, but no other analysis found or provided. The ED had just started in the position and was not able to speak to management of complaints prior to their start. There was risk that complaints were not addressed and areas for improvement required in the home would not have been identified when complaints were not documented and not reviewed and analyzed for trends.

Sources: 2021 and 2022 complaints binders, written quarterly complaints analysis and staff interviews. [s. 101.]

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 a documented record is kept in the home, that includes the nature of each verbal or written complaint, the date received, action taken, final resolution, and dates responses provided to complainants; also to ensure the documented record of complaints is reviewed and analyzed for trends at least quarterly, the results of the review and analysis taken into account in determining what improvements are required and a written record kept of the review and improvements made in response, to be implemented voluntarily.

WN #8: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to refuse consent to the treatment was fully respected and promoted.

A resident was administered a treatment, but did not sign a consent or give verbal consent to receive that treatment. The resident informed the inspector that they didn't want to receive that treatment, they thought it was for something different.

Sources: Interview with, observations of and record review for a resident, audits and staff interviews. [s. 3. (1) 11. ii.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

(A1)
1.The licensee has failed to comply with Compliance Orders.

a) Compliance Order #004, issued in inspection #2021_605213_0018, on August 16, 2021, with a compliance due date of November 26, 2021, required the licensee to complete monthly audits of new admissions for completion of tuberculosis (TB) screening and administration of required immunizations. The home was not able to provide any monthly audits of new admissions for completion of TB screening and administration of required immunizations completed between August 16, 2021, and February 1, 2022. Residents were at risk when the home was not aware of which residents were vaccinated and which were not.

b) Compliance Order #002, issued in inspection #2021_928577_0003, with a compliance due date of February 11, 2022, required the home to provide training to registered staff on the home's policies for medication administration; specifically related to the use of appropriate identifiers according to Best Medication Practices to ensure the resident is administered medications as prescribed. The training records indicated that not all registered staff completed the training before the compliance due date. The Acting DOC said that all registered staff completed the training, but all were not completed prior to the compliance due date. This presented a risk to residents related to medication management when staff didn't receive the training required in a timely manner.

c) Compliance Order #001, issued in inspection #2021_928577_0002, with a compliance due date of February 11, 2022, required the licensee to educate all registered staff on the home's medication policies specific to receiving, counting, storing and destroying controlled substances. The training records indicated that not all registered staff completed the training before the compliance due date. The Acting DOC said that all registered staff completed the training, but all were not completed prior to the compliance due date. This presented a risk to residents related to medication management when staff didn't receive the training required in a timely manner.

Sources: Inspection reports for inspections #2021_917213_0018, #2021_928577_0002 and #2021_928577_0003, training records, and staff interviews. [s. 101. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of all residents involved in an incident of suspected neglect.

A CIS report documented residents involved in an incident of suspected neglect, as “multiple residents” on the home area. The VPP verified the report to the Director did not include the names of the residents involved in the incident of suspected neglect. There was a risk that appropriate follow up was not completed for residents when their names were not included in the report to the Director.

Sources: CIS report, investigative documentation, and an interview with the VPP. [s. 104. (1) 2. i.]

2. The licensee has failed to ensure that the report to the Director included names of any staff members or other persons who were present at or discovered an incident of suspected abuse.

A CIS report documented the suspected verbal, physical and emotional abuse of residents. As part of the home's investigation notes, a staff name was crossed out and replaced by a different name and the CIS report to the Director was not amended to reflect this. The acting DOC verified the report to the Director did not include the correct name of the staff member. There was an increased risk to residents that appropriate follow up was not completed when the home failed to report the correct name of the staff member to the Director.

Sources: CIS report and an interview with the Acting DOC. [s. 104. (1) 2. ii.]

3. The licensee has failed to ensure that the report to the Director included whether a family member, person of importance or SDM of any of five residents involved in an incident of alleged abuse were contacted and the name of such persons, in response to the incident.

A CIS report documented the suspected verbal, physical and emotional abuse of five residents. The CIS report documented that relative(s), friend(s), designated contact(s) and/or SDMs were not contacted. The Acting DOC verified the report to the Director did not include whether family members or SDMs were contacted. There was risk to that appropriate follow up was not completed as a result.

Sources: CIS report and an interview with the acting DOC. [s. 104. (1) 3. iv.]

Issued on this 11st day of April, 2022 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by RHONDA KUKOLY (213) - (A2)
Inspection No. / No de l'inspection :	2022_917213_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012981-21, 012982-21, 012983-21, 012988-21, 016639-21, 016810-21, 017560-21, 017912-21, 018109-21, 018215-21, 018399-21, 019472-21, 019473-21, 019474-21, 019475-21, 019476-21, 000834-22, 001616-22 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 11, 2022(A2)
Licensee / Titulaire de permis :	Henley Place Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Henley Place 1961 Cedarhollow Boulevard, London, ON, N5X-0K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Lakie

To Henley Place Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_928577_0003, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131 (2) of O. Reg. 79/10.
Specifically, the licensee must:
a) Have a member of the management team or the charge nurse (if they themselves are not completing a medication pass), complete an in-person or telephone daily round for each unit to ensure all residents receive their morning medications in the time frame prescribed. The daily round must be documented and completed until the order is complied by the Ministry of Long-Term Care (MLTC).
b) Have a registered nursing staff member complete one full morning medication pass on a unit under direct supervision, repeat until all medications are given in the time frame prescribed. Provide coaching and training when applicable and document what coaching was provided, date, time, and name of supervisor.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that a registered nursing staff member administered drugs to 23 residents as specified by the prescriber.

A registered nursing staff member administered morning medications to 23 residents two to three hours past the time for administration identified in the electronic Medication Administration Record (eMAR) and physicians' orders. Some of these late medications were high risk medications, including narcotics, psychotropics, and insulin. One resident complained that the delayed administration of their scheduled narcotic caused them to have pain. An Associate Director of Care (DOC) said that they were not aware of the late medication administration and that their expectation was that medications were administered on time as prescribed.

Sources: Observations of medication administration, residents’ eMARs and progress notes, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal harm.
Scope: The scope of this non-compliance was widespread with 23 out of 26 residents’ medications administered late.
Compliance History: A Compliance Order was issued December 1, 2021, and amended January 5, 2022, in inspection #2021_928577_0003 with a compliance due date of January 26, 2022.
(721442)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 28, 2022(A2)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_605213_0018, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with s. 229 (10) of O. Reg. 79/10.
Specifically, the licensee must:
a) Complete an audit of all current residents for completion of tuberculosis screening and all required immunizations as per the publicly funded immunization schedule.
b) Ensure that all previously admitted are offered, and if eligible and consented, receive all required immunizations as per the publicly funded immunization schedule.
c) Ensure that all newly admitted are offered, and if eligible and consented, receive all required immunizations as per the publicly funded immunization schedule.
d) Develop and implement a process on admission, related to tuberculosis screening and all required immunizations, including orders, consents and documentation. The process must be documented to include who is responsible, time frames, documentation required and monthly auditing of new admissions for completion.
e) Communicate the process to all registered staff and persons responsible for admitting residents and completing screening, consents and immunizations.
f) Complete monthly audits of new admissions to ensure completion of tuberculosis screening and administration of all required immunizations. Audits are to be documented with date completed, person completing, resident name, date of admission, items audited, results and follow up actions taken. Audits are to be completed for six months.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that residents were offered immunization against influenza, pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules.

All residents were not offered immunization against influenza, pneumococcus, tetanus and diphtheria, in accordance with the publicly funded immunization schedules, putting them at risk for infection. The Acting DOC and an Associate DOC said that all vaccinations were put on hold after an error in documentation of influenza vaccination occurred, as well as a significant covid-19 outbreak.

Sources: Audit of vaccinations and TB screening, health records and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was a pattern with 66 out of 162 residents (40 per cent), not having the required immunizations.
Compliance History: A Compliance Order was issued August 16, 2021, in inspection #2021_605213_0018, with a compliance due date of November 26, 2021.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 28, 2022(A2)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_928577_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6. (1) (c) of the Long-Term Care Homes Act, 2007. Specifically, the licensee must:
a) Review orders related to a specific treatment for two residents for clear direction and discuss revisions as needed with the resident's physician or nurse practitioner.
b) Review and revise two resident's care plans to ensure clear direction is provided for registered staff and personal support workers, specific to their respective roles, regarding a specific treatment. Ensure that the direction matches the orders.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care for two residents provided clear direction to staff and others who provide direct care to the residents.

Two residents had unclear and conflicting direction in their plans of care and both had no direction in Point of Care (POC) for Personal Support Workers (PSWs) for a special need. Associate DOCs said the care plans did not provide clear direction and that there should have been direction in POC for PSWs. Two residents were at risk of care not being provided properly when the plans of care did not provide clear direction.

Sources: Observations of and health records for two residents, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was a pattern with two out of three residents’ plans of care not providing clear direction.
Compliance History: A Compliance Order was issued December 1, 2021, and amended January 5, 2022, in inspection #2021_928577_0003.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 14, 2022

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_605213_0018, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

The licensee must be compliant with s. 6 (2) of the LTCHA. Specifically, the licensee must:

a) Review and revise (if appropriate) the home's process for assessing residents' related to a specific need, including the process for ensuring that resident plans of care are based on the assessments. Document the process including who is responsible for assessments, updating plans of care and timelines. The process must be identified for newly admitted residents as well as for existing residents if there is a change in their condition.

b) Communicate the process to all registered staff in the home and anyone else involved in the assessment of the specific need and updating plans of care.

c) Complete an audit of assessments completed and plans of care related to the specific need, specifically to determine if the plan of care matches and is based on the assessments completed. Keep a record of the communication, the content and the date communicated.

d) Revise and ensure that the plan of care for five identified residents matches and is based on assessments completed.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that care set out in the plan of care for residents was based on assessments of the residents and the needs and preferences of the residents.

Direction in the plans of care for five residents did not match assessments completed. This put residents at risk for injury. The Acting DOC and an Associate DOC said that the care plans for a number of residents were not based on assessments completed, and that the expectation was that the direction in the care plan matched the assessment.

Sources: Observations of residents and resident health records, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm.
Scope: The scope of this non-compliance was widespread with five out of six (83 per cent) residents’ plans of care not based on an assessment of the resident.
Compliance History: A Compliance Order was issued August 16, 2021, in inspection #2021_605213_0018. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 28, 2022(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2021_605213_0018, CO #007;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(A2)
The licensee must be compliant with s. 24 (1) of the LTCHA.
Specifically, the licensee must prepare, submit and implement a plan to ensure that the home’s abuse and neglect policy is complied with related to immediate reporting. The plan must include but is not limited to:
a) It must be created by the management team as a whole, with responsibilities outlined for all aspects of the plan, as well as the home’s abuse and neglect policy and process for immediate reporting.
b) The person(s) responsible for and the process for overseeing and ensuring completion of immediate reporting of abuse and/or neglect and all required reportable items, required notifications, and documentation of all of the above.
c) Timelines for completion.
Please submit the written plan for achieving compliance for inspection 2022_917213_0005 to Rhonda Kukoly, LTC Homes Inspector, MLTC, by email to LondonSAO.MOH@ontario.ca by April 28, 2022.
Please ensure that the submitted written plan does not contain any PI/PHI.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that staff members who suspected abuse and neglect of residents that resulted in risk of harm, immediately reported the suspicion and the information upon which it was based, to the Director.

There were three reports of alleged abuse and/or neglect reported by staff members to the management of the home. They were reported days after the alleged incidents. Residents were put at continued risk of abuse and neglect when staff did not report alleged abuse immediately.

Sources: Three CIS reports, investigative documentation, witness statements, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal risk.
Scope: The scope of this non-compliance was isolated with three out of seven (43 per cent) residents affected.
Compliance History: A Compliance Order was issued August 16, 2021, in inspection #2021_605213_0018, with a compliance due date of November 26, 2021.
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 27, 2022(A2)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

(A2)
The licensee must be compliant with s. 19 (1) of the LTCHA.
Specifically, the licensee must prepare, submit and implement a plan to ensure staff are providing care to residents as specified in their plan of care, that the home's abuse and neglect policy is complied with. The plan must include but is not limited to:
a) It must be created by the management team as a whole, with responsibilities outlined for all aspects of the plan, as well as the home's abuse and neglect policy and the prevention of abuse and neglect of residents.
b) The person(s) responsible for and the process for overseeing and ensuring compliance with the home's abuse and neglect policy and the prevention of abuse and neglect of residents.
c) Timelines for completion.
Please submit the written plan for achieving compliance for inspection 2022_917213_0005 to Rhonda Kukoly, LTC Homes Inspector, MLTC, by email to LondonSAO.MOH@ontario.ca by April 28, 2022.
Please ensure that the submitted written plan does not contain any PI/PHI.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse and/or neglect.

O. Reg 79/10 defines abuse as follows:
- Emotional abuse means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident
- Physical abuse means, subject to the use of physical force by anyone other than a resident that causes physical injury or pain
- Verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident

The home notified the Ministry of Long-Term Care of a report of alleged abuse of residents. Witness statements, the home’s investigation notes, interviews with staff and management of the home verified that the alleged abuse did occur.

Sources: CIS report, resident clinical records, the investigation documentation, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal harm.
Scope: The scope of this non-compliance was a pattern with 12 out of 31 (39 per cent) residents affected.
Compliance History: A Compliance Order was issued August 16, 2021, in inspection #2021_605213_0018, and a Voluntary Plan of Correction was issued January 3, 2020, in inspection #2020_ 788721_0048.
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 27, 2022(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(A2)
The licensee must be compliant with s. 23 (1) of the LTCHA.
Specifically, the licensee must prepare, submit and implement a plan to ensure that the home’s abuse and neglect policy is complied with related to immediate investigations, actions taken, required notifications, and documentation. The plan must include but is not limited to:
a) It must be created by the management team as a whole, with responsibilities outlined for all aspects of the plan, as well as the home’s abuse and neglect policy and the process for immediate investigations, actions taken, required notifications, subsequent reporting to the Director and documentation.
b) The person(s) responsible for and the process for overseeing and ensuring completion of immediate investigation of abuse and/or neglect, appropriate actions taken, required notifications, and documentation of all of the above.
c) Timelines for completion.
Please submit the written plan for achieving compliance for inspection 2022_917213_0005 to Rhonda Kukoly, LTC Homes Inspector, MLTC, by email to LondonSAO.MOH@ontario.ca by April 28, 2022.
Please ensure that the submitted written plan does not contain any PI/PHI.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that alleged incidents of abuse of residents that were reported to the licensee, were immediately investigated, and appropriate action was taken in response, including that the residents' substitute decision-maker (SDM), if any, were notified immediately.

a) The home notified the Ministry of Long-Term Care of a report of alleged abuse of residents. However, six other residents were also identified during the investigation. The Acting DOC verified the alleged incidents of abuse of the six other residents were not immediately investigated, and the appropriate action was not taken, including interviewing and assessing the residents, and notifying SDMs. (563)

b) The home's management team were notified of an allegation of abuse of a resident. The investigation was not completed immediately, and appropriate actions not taken until over a month later, and the resident's SDM was not notified of the alleged abuse. The Acting DOC acknowledged that the investigation should have been completed immediately with appropriate actions taken, and the resident's SDM should have been notified. (721442)

Residents were put at further risk of harm when the alleged incidents of abuse of residents were not investigated, and appropriate actions were not taken.

Sources: CIS reports, resident clinical records, the investigation documentation, the Primacare Policy Number 06-02: Zero Tolerance of Resident Abuse/Neglect, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was minimal harm.
Scope: The scope of this non-compliance was a pattern with 7 out of 12 residents (58 per cent) of residents reviewed affected.
Compliance History: In the past 36 months, a Compliance Order was issued August 16, 2021, in inspection #2021_605213_0018.
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 27, 2022(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11st day of April, 2022 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by RHONDA KUKOLY (213) - (A2)

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Service Area Office / Bureau régional de services : London Service Area Office