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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 22, 2022
Inspection Number 2022_1473_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Henley Place Ltd.

Long-Term Care Home and City
Henley Place, London

Lead Inspector
Peter Hannaberg (721821)

Inspector Digital Signature
Peter Benjamin Hannaberg
Digitally signed by Peter Benjamin Hannaberg
Date: 2022.07.22 11:22:09 -04'00'

Additional Inspector(s)
Debbie Warpula (577); Cheryl McFadden (745).
Inspectors 741751 (Vernon Abellera), 741771 (Lillian Akapong), and 741070 (Maureen Kelly) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 7-10, and 13-16, 2022.

The following intake(s) were inspected:

- Intake #006240-22. Follow-up to CO#002 from inspection #2022_917213_0005 regarding r. 229. (10), Compliance Due Date Apr 14, 2022.
- Intake #006239-22 . High Priority - Follow-up to CO#001 from inspection #2022_917213_0005 regarding r. 131. (2), Compliance Due Date Apr 14, 2022.
- Intake #006238-22. High Priority - Follow-up to CO#007 from inspection #2022_917213_0005 regarding s. 23. (1), Compliance Due Date May 13, 2022.
- Intake #006237-22. High Priority - Follow-up to CO#006 from inspection #2022_917213_0005 regarding s. 19. (1), Compliance Due Date May 13, 2022.
- Intake #006236-22. High Priority - Follow-up to CO#005 from inspection #2022_917213_0005 regarding s. 24. (1), Compliance Due Date May 13, 2022.
- Intake #006235-22. High Priority - Follow-up to CO#004 from inspection #2022_917213_0005 regarding s. 6. (2), Compliance Due Date Apr 14, 2022.
- Intake #006234-22. High Priority - Follow-up to CO#003 from inspection #2022_917213_0005 regarding s. 6. (1), Compliance Due Date Apr 14, 2022.
- Intake #011432-22. CI: 3045-000043-22. Fall of resident #011. Sustained left hip fracture.

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	131 (2)	2022_917213_0005	001	Debbie Warpula (577)
O. Reg. 79/10	229 (10)	2022_917213_0005	002	Debbie Warpula (577)
LTCHA, 2007	6 (1)	2022_917213_0005	003	Debbie Warpula (577)
LTCHA, 2007	24 (1)	2022_917213_0005	004	Peter Hannaberg (721821)
LTCHA, 2007	19 (1)	2022_917213_0005	005	Peter Hannaberg (721821)
LTCHA, 2007	19 (1)	2022_917213_0005	006	Peter Hannaberg (721821)
LTCHA, 2007	23 (1)	2022_917213_0005	007	Debbie Warpula (577)

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION IPAC PROGRAM

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg 246/22 s. 102 (8)

The licensee has failed to ensure that the infection prevention and control program required under subsection 23 (1) of the Act complies with the requirements of this section: all staff participate in the implementation of the infection prevention and control program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

Rationale and Summary
Observations in June 2022, noted Contact Precaution signage was posted outside resident of two resident rooms. Inspector #721821 noted there were no gowns in the isolation cart outside of the room. Further observations in June 2022, noted Contact Precaution signage posted outside of two additional resident rooms. On both occasions, there were no gloves on

the isolation cart. In June 2022, Droplet and Contact Precaution signage was posted outside of a resident's room and Inspector #577 noted there were no gowns on the isolation cart.

Registered Practical Nurse (RPN) #100 and RPN #101 advised that gloves were required to be available at point of care, in the PPE bin for residents on Contact Precautions for MRSA/VRE. PSW #102 advised that gowns should have been available at point of care in their PPE bins for a resident.

ADOC #103 advised that residents on Contact and Droplet Precautions were required to have appropriate PPE at point of care in their PPE bin.

Staff not implementing the home's IPAC program by not having gloves and gowns available at point of care, put residents and staff at risk of potentially spreading healthcare associated infections.

Sources: IPAC tour of the home, home's resident list with Antibiotic Resistant Organisms (ARO), the home's policy "Contact Precautions" (#03-10 revised 2016), "Respiratory Outbreak" (#006070.00), a resident's progress notes, IPAC observations and interviews with the ADOC and other staff.

[#577]

WRITTEN NOTIFICATION GENERAL REQUIREMENTS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg 246/22 s. 34 (1) 1

The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 11 to 20 of the Act, and each of the interdisciplinary programs required under section 34 of Ontario Regulation 246/22.

Specifically, the licensee has failed to ensure that the Falls Prevention and Management Program included goals and objectives.

Rationale and Summary
A review of the home's policy "Falls – 09-01" revised September 2021, did not contain goals and objectives for the Falls Prevention and Management Program. The "Falls Prevention and Restraint Committee Terms of Reference – 09-03" revised September 2013, indicated that goals for the Falls Prevention Program would be developed annually to guide the development and implementation of the program. A review of falls incidents would be reviewed at monthly meetings and recommendations would be shared with the interdisciplinary team. All fall incidents would be reviewed and analyzed monthly, including fall prevalence and incidence, identifying trends, and a plan would be developed for improvement and evaluation. The information was to be shared with residents, families and the interdisciplinary team. The Fall Prevention Program would be evaluated at the first meeting at the beginning of the year and a written evaluation would be provided.

During an interview with the DOC, they provided Inspector #577 with a document "Annual Program and Departmental Evaluation" for their Falls Prevention and Management Program, dated December 1, 2020. The document included goals and objectives for the upcoming year (2021). The DOC advised that the Fall's Committee was composed of ADOC #117 and themselves, and their last meeting was in September 2020.

The home's Fall's Committee last met in September 2020, and their annual goals and objectives to guide the development and implementation of the program were last developed and reviewed in December 2020.

Sources: the home's policy "Falls" (#09-01 revised September 2021), "Falls Prevention and Restraint Committee Terms of Reference – 09-03" revised September 2013 and interviews with ADOC #117 and the DOC.

[#577]

WRITTEN NOTIFICATION AIR TEMPERATURE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: FLTCA, 2021 s. 24 (3)

The licensee has failed to ensure that the temperature required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
Inspector #721821 was provided documentation of the daily recorded air temperatures in the Long-Term Care Home for the months of May and June up to the date of inspection. Hourly air temperature records were also provided for each resident home area which are documented by nursing or PSW staff.

The daily air temperature documentation provided by the Environmental Service Manager (ESM) #107, shows no record of air temperatures in two resident rooms and one common area on each floor in the afternoon and in the evenings in May and June of 2022. The documentation provided by the staff on the home areas also showed several days from May 15th to June 14th where documentation could not be provided to show that temperatures had been measured and recorded as required.

When the daily temperature records provided by ESM #107 were combined with the hourly air temperature records from the nursing or PSW staff, the minimum requirements for air temperature measuring and recording were missed on at least one instance on each of the following days: May 15 – 30, and June 1 – 8, 2022.

During an interview, PSW #111 stated that PSWs or the nurse on the home area are responsible for measuring and documenting the air temperatures in the home. The ESM #107 stated that they or their assistant are responsible for measuring and recording the air

temperatures throughout the home. ESM #107 stated they consistently recorded those temperatures in the mornings only.

During an interview with the Executive Director (ED) #109, Inspector #721821 confirmed that air temperature logs were incomplete on multiple days in multiple home areas. ED#109 stated that the air temperatures should be measured and recorded three times per day, but that it hadn't been done based on the records provided.

The Assistant Director of Care (ADOC) #117 confirmed with Inspector 721821 that all temperature logs that were available at the time of the inspection had been provided.

Sources: Daily air temperature logs, hourly air temperature logs; interviews with ESM #107, ED #109, PSW #110, PSW #111, RPN #112, and ADOC #117.

[721821]

WRITTEN NOTIFICATION AIR TEMPERATURE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with: O. Reg. 246/22 s. 24 (4)

The licensee has failed to ensure air temperatures are being measured and documented in all resident rooms which are not served by air conditioning daily between the hours of 12:00 and 5:00 PM.

Rationale and Summary
The home's Heat Related Illness Prevention and Management (Reference number 005210.00, revised June 2022) plan states that all home areas are to submit daily temperature monitoring reports for resident bedrooms which are not served by air conditioning.

Environmental Services Manager (ESM) #107 and Executive Director (ED) #109 each confirmed that the resident bedrooms are not served by air conditioning at this time.
During an interview with RN #113, they stated that they do not measure and document the temperatures in each resident bedroom. RN #113 stated that two bedrooms on each home area are measured and recorded on the air temperature log.

The ESM #107 stated during an interview that the temperatures which are recorded using the thermometer at the nursing desk are assumed to be the temperatures in the resident bedrooms. During a follow-up interview with ESM #107, they stated that a new process was being developed to measure and record the temperatures in all resident rooms but had not been implemented at this time.

While conducting measurements of the air temperatures in resident bedrooms in the home, the temperature was found to be 28C which places residents at risk for heat related illness.

Sources: the home's Heat Related Illness Prevention and Management (Reference number 005210.00, revised June 2022); interviews with RN#113, ESM #107, ED #109; and air temperature measurements.
[721821]

COMPLIANCE ORDER [CO#001] FALLS PREVENTION AND MANAGEMENT

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: O. Reg. 246/22 s. 53 (1) 1

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with O. Reg 246/22 s. 53 (1) 1. The licensee shall: A) Ensure that a post fall assessment is completed for a resident after each fall. B) Ensure that a Head Injury Routine is completed when required by the home's falls program for a resident fall with head injury, suspected head injury and for all unwitnessed falls. C) Ensure that fall prevention interventions are identified in the care plan and implemented when a resident's fall risk level has been determined.

Grounds
Non-compliance with: O. Reg 246/22 s. 53 (1) 1 The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home. **Rationale and Summary** A Critical Incident System (CIS) report was submitted to the Director in June of 2022, concerning a resident who had a fall resulting in a serious injury which required hospitalization. A review of the home's policy "Falls - #09-01" revised September 2021, indicated that staff were required to initiate a head injury routine (HIR) if a head injury was suspected or if the fall was unwitnessed. They were to complete a post fall assessment and update the resident's plan of care if required. Falls prevention equipment would be accessible to staff at all times, that could help prevent a resident fall. Interventions may include non-slip socks, chair alarms, personal alarms, bed alarms, night light, hip protectors, "reachers", fall mats and helmets.

Items would be determined and maintained by the Falls Committee. The Director of Care (DOC) or designate would update the care plan with the associated risk level and interventions upon completion of the falls risk assessment and monitor preventative interventions and evaluate the effectiveness on an ongoing basis and with quarterly reviews.

A review of the progress notes indicated that the resident had fallen previously on multiple occasions. A review of the resident's care plan did not indicate a fall focus or interventions to prevent a fall.

Inspector #577 reviewed the post fall assessments for the resident and noted that there wasn't a post fall assessment completed after one of the falls. A review of the resident's HIR for an unwitnessed fall was missing documentation on three specific times as required.

PSW #118 and RPN #100 both confirmed that the resident did not have fall interventions or equipment in place to prevent falls. They both advised that the resident used their call bell to call for assistance when needed.

During an interview with ADOC/Falls Lead #117, together with Inspector #577, reviewed the resident's records. They confirmed that a post fall assessment had not been completed, the HIR was missing documentation on three specific times, and the resident's care plan did not indicate a fall focus or interventions to prevent a fall.

The resident suffered actual harm when they fell, resulting in a serious injury and hospitalization. The resident's care plan did not contain a falls focus or interventions to prevent a fall even though the resident had fallen multiple times.

Sources: Critical Incident System (CIS) report #3045-000043-22, the home's policy "Falls" (#09-01 revised September 2021), "Head Injury Routine" (#08-45 revised September 2021), a resident's clinical record and interviews with ADOC #117 and other staff.

This order must be complied with by July 26, 2022
[#577]

COMPLIANCE ORDER [CO#002] GENERAL REQUIREMENTS

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2
Non-compliance with: O. Reg. 246/22 s. 34 (1) 3

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with O. Reg 246/22 s. 34 (1) 3.

The licensee shall:

A) Ensure that the home's Falls Prevention Program is evaluated by the compliance due date and updated if required.

B) Ensure that the Fall's Committee meets monthly.

Grounds

Non-compliance with: O. Reg 246/22 s. 34 (1) 3

The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 11 to 20 of the Act, and each of the interdisciplinary programs required under section 53 of Ontario Regulation 246/22.

Specifically, the licensee has failed to ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
A review of the home's policy "Falls – 09-01" revised September 2021, indicated that the Falls Prevention Program was to be reviewed annually and as required.

A review of the home's policy "Falls Prevention and Restraint Committee Terms of Reference – 09-03" revised September 2013, indicated that a review of individual incidents of falls would be reviewed at monthly meetings and recommendations would be shared with the interdisciplinary team. All resident falls would be reviewed and analyzed monthly, including fall prevalence and incidence, identifying trends, and a plan would be developed for improvement and evaluation. The information was to be shared with residents, families and the interdisciplinary team. The Fall Prevention Program would be evaluated at the first meeting at the beginning of the year and a written evaluation would be provided.

During an interview with the DOC, they provided Inspector #577 with a document "Annual Program and Departmental Evaluation" for their Falls Prevention and Management Program, dated December 1, 2020. The document included goals and objectives for that upcoming year; a summary of the effectiveness of the program and identified areas for change and improvement. They advised that there were no further evaluations since December 2020.

The home's Fall's Committee last met in September 2020. Their annual goals and objectives to guide the development and implementation of the program were last developed and reviewed in December 2020; evaluation of the Fall's program was done in December 2020.

Sources: the home's policy "Falls" (#09-01 revised September 2021), "Falls Prevention and Restraint Committee Terms of Reference – 09-03" revised September 2013 and interviews with the DOC.

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This order must be complied with by August 23, 2022
[#577]

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

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