Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 6, 2023	
Inspection Number: 2023-1473-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Henley Place Limited	
Long Term Care Home and City: Henley Place, London	
Lead Inspector Ali Nasser (523)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30, 31, 2023 and June 1, 2023

The following intake(s) were inspected:

- Intake: #00085158, complaint related to resident care concerns.
- Intake: #00086062, incident related to resident to resident responsive behaviours.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions were implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rational and Summary:
The home submitted a Critical Incident System “CIS” report related to resident’s responsive behaviours.

In an interview a staff member said they were redirecting a resident with responsive behaviours, the resident was getting aggressive. The PSW did not call for assistance and left resident in the hallway.

In an interview the Administrator said the staff were expected to call for help and assistance when the resident became aggressive.

The staff did not call for assistance and help when the resident was getting aggressive which put other resident at harm.

Sources: record reviews and staff interviews. [523]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale & Summary:
The Infection Prevention and Control “IPAC” Standard for Long-Term Care Homes documented under section 9.1 "The licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: d) proper use of Personal Protective Equipment “PPE”, including appropriate selection, application, removal, and disposal."

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Ontario Regulation 22/246 s. 11 (1) (b) states, “Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.”

A complaint was reported to the Ministry of Long-Term Care identifying an IPAC concern stating staff on certain dates, during a COVID outbreak wore the same PPE to different resident rooms.

The home's PPE policy included specific directions for removal of PPE before leaving resident rooms.

A review with the Administrator of the video surveillance on those dates showed multiple staff members did not remove their PPE before leaving the resident’s room. Staff were observed going into a different resident room wearing the same PPE. The Administrator said the home’s process was for staff to remove their PPE before leaving the resident’s room and not to wear the same PPE to another resident room.

The goal of the IPAC program was to optimize safety and to the prevent of the spread of infections among those inside the home. The staff wearing the same PPE to different resident rooms placed residents at risk.

Sources: observations, review of policies; and staff interviews. [523]