Ontario

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

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

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

Original Public Report

Report Issue Date: November 27, 2024
Inspection Number: 2024-1473-0005
Inspection Type: Complaint Critical Incident
Licensee: Henley Place Limited
Long Term Care Home and City: Henley Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 31, 2024, and November 1, 4, 5, 7, 8, 12, 13, 2024, with November 6, 2024 conducted both on-site and off-site.

The following intake(s) were inspected:

Intake #00125984 and Intake #00130985 were complaints related to short staffing;
Intake #00130784 and Intake #00131212 were complaints related to short staffing and housekeeping;
Intake #00126799 was a complaint regarding alleged abuse;
Intake #00124035/ Critical Incident (CI)#3045-000075-24 related to medication use requiring a hospital transfer;
Intake #00125937/CI#3045-000081-24 related to continence care;
Intake #00128557/CI#3045-000086-24 related to dining and snack service;
Intake #00128890/CI#3045-000087-24 related to Falls Prevention and Management;
Intake #00129308/CI#3045-000088-24 related to a declared outbreak; and
Intake #00130855/CI#3045-000092-24 and Intake #00126807 were related to

alleged verbal and physical abuse.

The following intakes were completed during this inspection:

Intake #00125538/CI#3045-000079-24 related to a finalized outbreak; and Intake #00128134/CI#3045-000085-24 and Intake #00130237/CI#3045-000089-24 were related to Falls Prevention and Management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident

The licensee has failed to ensure the clear direction provided in a resident's plan of care regarding the use of an assistive device.

Rationale and Summary
On a specific date, it was observed that a resident was utilizing an assistive device in an incorrect position.

A review of the resident's clinical records indicated that they used a specific type of assistive device due to their physical status. The care plan did not include how the device was to be positioned or the functionality of the device. The plan of care for the resident stated how staff should assist with mobility by utilizing the assistive device, without providing clear instructions regarding the positioning for use.

In an interview, a personal support worker (PSW) stated that the assistive device was positioned for the comfort of the resident, and to prevent the resident from self-transferring. The PSW indicated that they would position the device as needed.

However, after reviewing the resident's clinical records, the associate director of care (ADOC)/ falls lead confirmed that the device should not be positioned differently for any purpose.

On a subsequent date, the Point of Care (POC) records were updated to instruct staff not to position the assistive device for the resident, and a visual card was displayed emphasizing the information.

Sources: The resident's clinical records, interviews with staff, and the ADOC.

Date Remedy Implemented: November 13, 2024

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)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The licensee has failed to ensure that Additional Precautions were followed in the Infection Prevention and Control (IPAC) program in accordance with the IPAC Standard for Long-Term Care Homes (LTCH), revised September 2023.

Additional Requirement 9.1 under the IPAC Standard directs the licensee to ensure that Routine Practice and Additional Precautions are followed in the IPAC program. At minimum, section 9.1 (d), for Additional Precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal, and disposal.

Specifically, the licensee did not ensure that a registered practical nurse (RPN) removed their PPE after exiting a resident room who was COVID-19 positive and on droplet and contact precautions. The RPN continued to assist another resident who was not on additional precautions.

Rationale and Summary
There was a COVID-19 outbreak declared in the LTCH and was ongoing during the inspection. The home's protocols identified that N95 respirator and eye protection were required on home areas in outbreak.

During observations on an outbreak home area, the RPN was observed exiting a resident room with signage indicating that the resident was on droplet and isolation precautions, specific to being COVID-19 positive. The staff member did not remove their N95 respirator mask or their eye protection. The RPN entered a co-residents room who was not on isolation precautions, provided direct care to the resident and then exited the room without doffing their N95 mask and eye protection.

The home's Infection Control policy titled "Appendix II: Guidelines- Droplet/Contact Precautions" stated routine practices are to be followed at all times and PPE will be changed following procedures, between residents, or when heavily contaminated/torn/split during a procedure.

The assistant director of care (ADOC) confirmed that droplet/contact precaution signage would be posted at the room for residents who were COVID-19 positive. The inspector reviewed the home's policy regarding the removal of PPE, and asked about routine practices for the removal of the N95 respirator and eye protection upon exiting a resident's room who was COVID-19 positive. The ADOC stated that in theory, the staff were to remove all PPE, however, staff were keeping the N95 respirator and eye protection on, but removing the gown and gloves. They said that if the staff's N95 mask was soiled or wet, or if the staff were going on break, then they were to remove the mask in those instances. The ADOC verified the information with the home's infection control consultant.

The infection control consultant confirmed that it was best practice to remove all PPE, including eye protection and N95 mask, upon exiting a droplet and contact precaution room. They stated that based on the recommendations made by Public Health Ontario (PHO) or what the infection control consultant had put in place, the staff would put on fresh PPE prior to entry into another resident room.

When the RPN did not remove all PPE after attending to a resident on droplet and contact precautions, the risk of transmission of infectious disease was increased.

Sources: Home area and staff observations, review of the IPAC Standards, the home's policy "Appendix II: Guidelines- Droplet/Contact Precautions", interview with the home's infection control consultant and the ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee failed to ensure that the home's fall prevention and management program was followed, specifically the requirement for staff to complete a quarterly fall risk assessment for a resident.

Pursuant to Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that the home implemented a fall prevention and management program and that the program was adhered to.

Specifically, staff did not comply with the requirements outlined in the home's "Falls Prevention & Management Program" policy related to the completion of quarterly fall risk assessments.

Rationale and Summary
A review of the home's "Falls Prevention & Management Program" policy stipulated that a comprehensive fall risk assessment must be completed quarterly for each resident in Point Click Care (PCC).

A review of a resident's clinical records revealed the resident had multiple falls. The resident records showed no fall risk assessment had been completed quarterly. The initial fall risk assessment was conducted upon admission and the next was completed on a subsequent date after the resident sustained an injury due to a fall.

The associate director of care / falls lead confirmed that the required quarterly assessments were not conducted between admission and the subsequent date of the fall.

By failing to complete the fall risk assessments as required, placed the resident at risk as staff may not have been fully aware of their fall risks.

Sources: A resident's clinical records, the home's "Falls Prevention & Management Program" policy, and staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in their plan.

Rationale and Summary
The home submitted a critical incident to the Director which indicated that a resident was not provided needed care.

By not providing the care ordered and needed at the time, the resident was left in pain and discomfort.

Sources: A resident's clinical records, homes investigation records, Critical Incident System report, and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee had failed to ensure that when a resident exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A review of a resident's clinical records showed an initial skin assessment for an altered area of skin integrity was completed in the Skin and Wound Care application on a specific date. However, the documentation in Point Click Care (PCC) indicated that no subsequent weekly skin assessments were completed after this date, until the area healed.

The home's skin and wound care policy required that if a new skin alteration was identified, a Wound Assessment must be completed via the Skin and Wound Care application in the electronic health record. Additionally, a weekly re-evaluation of the wound is required until the area has healed or resolved.

The skin and wound care lead and a registered nurse (RN) confirmed that after reviewing the PCC documentation and skin and wound care application, weekly skin reassessments were not conducted for the resident following the altered area of skin integrity. They acknowledged that staff were expected to complete these weekly reassessments until the wound had healed. The RN further noted that a progress notes should have been documented if the resident refused the assessment or if there was any reason the weekly reassessment was not completed.

There was no identified impact on the healing of the resident's altered area of skin integrity due to the failure to complete weekly reassessments, as the wound had healed.

Sources: Resident clinical record review, and staff interviews.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act

s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to ensure that a final report regarding a reported incident of responsive behaviours by a resident, which affected multiple residents, was submitted to the Director within the required 10-day period.

Rationale and summary
An incident was reported through the after hours Critical Incident Reporting system, which mentioned alleged abuse by a resident towards co-residents. Documentation in Point Click Care (PCC) confirmed that the resident's behaviours affected multiple residents, with one resident sustaining an injury.

Upon reviewing the Critical Incident System (CIS), no final report of the critical incident was found. A final report was required to include a description of the incident, the individuals involved, actions taken in response to the incident, and an analysis and follow-up actions. According to the Ministry of Long-Term Care's Reporting Requirements for LTC Homes, a final report must be submitted to the Director within 10 days of the home becoming aware of the incident if it cannot be immediately completed.

A registered nurse (RN) confirmed that they were instructed by the executive director (ED) to report the incident to the Ministry. The ED stated they were unaware of any residents being affected or injured by the incident or by the resident's responsive behaviours. The ED indicated that they were not sure why the CI was not submitted.

Failure to ensure that an incident of alleged abuse was appropriately reported to the Director created a missed opportunity for the home to investigate, respond and take appropriate actions in a timely manner.

Sources: Multiple resident clinical records, interviews with staff and the ED.

COMPLIANCE ORDER CO #001 Dining and snack service

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Review and revise the home's meal and snack service policies and procedures, as well as temperatures at point of service, to ensure that food and beverages for all meal times, are served at safe and palatable temperatures. The policies and procedures must include the following:
- parameters for safe and palatable temperatures when serving hot beverages and food items
- information on what temperatures provide resident safety, comfort, and beverage satisfaction, how to achieve comfortable and safe temperatures, and
- a process for implementing corrective action, if required, to ensure that hot beverages are served at a safe and palatable temperature

B) Develop and implement an auditing process to ensure that residents are being provided with safe and palatable foods and fluids in accordance to the revised home's policies and procedures.

C) The audits must be completed at least weekly, until this compliance order is complied by an inspector. Ensure that audits include the dates, name of audited staff member, and signature of the staff member completing the audit as well as any corrective actions taken if issues are

identified during the auditing process.

D) Provide training to all dietary staff, Personal Support Workers (PSWs), and all others who may be involved with point of service for dining. Maintain a record of the training content, dates, names of staff and signature, and who provided the training.

Grounds
The licensee has failed to ensure that food and fluid was served at a temperature that was both safe and palatable to two residents.

Rationale and Summary
A critical incident report was submitted to the Director involving a resident who sustained an injury due to a hot food item.

The home's Food Temperature Point of Service Record on the date of the injury, showed the temperature of the food item to be documented as 169 degrees Fahrenheit.

A personal support worker (PSW) stated that they were serving lunch in the dining room on the specific date, and was informed that the resident had come into contact with the hot food item. The PSW said that the resident verbalized that the food item was hot. When asked if the home had documented procedures for staff to follow to ensure hot foods are served at a safe temperature, they said no, not that they were aware of. The PSW stated that the food item on the date of the incident was too hot as it caused injury to the resident.

According to the residents' progress notes, the injury was not assessed by nursing staff until the next day, when two PSWs identified the injury during morning care. Another PSW stated that staff should have informed the nurse when the incident occurred.

During the inspection, the inspector was informed that another resident had a hot fluid item cause injury to them during the dinner meal service. The residents care records indicate that the injury was monitored for skin impairment. The Food Temperature Point of Service Record showed no documented temperatures recorded for the fluid item.

The home's policy "Food Temperature – Point of Service" dated May 2023, did not contain

information specific to safe food temperatures or procedures for staff to follow to ensure that residents were served foods that are safe and palatable. The policy stated that food temperatures must be a minimum of 140 degrees Fahrenheit for hot food but did not specify maximum temperatures.

The Director of Care confirmed that the home's policies did not specify upper limits of hot food items prior to service and there was no direction to staff on how to ensure foods are served to residents at a safe and palatable temperature.

There was no documented process in place to ensure that foods and fluids were served at a temperature that was both safe and palatable, which impacted two residents when hot food and fluids caused injury.

Sources: Critical Incident Report, resident electronic health records, the licensee's policy titled "Food Temperature – Point of Service", the food temperature logs, interviews with personal support workers and the director of care.

This order must be complied with by January 31, 2025

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.