Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2014	2014_229213_0033	L-000395-14	Complaint

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9

Long-Term Care Home/Foyer de soins de longue durée

Henley Place
1961 Cedarhollow Boulevard, LONDON, ON, N5X-0K2

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

RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 21, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, an Associate Director of Care, 3 Registered Practical Nurses and a Family Member.

During the course of the inspection, the inspector(s) reviewed health records and the home's internal investigation records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the Resident or the Substitute Decision Maker (SDM) has been provided the opportunity to participate fully in the development and implementation of the plan of care as evidenced by:
a) Record review revealed that Resident #001 had a change in condition.
b) Record review revealed no documentation regarding notification of Resident #001's family/SDM regarding the Resident's change of status.
c) The Director of Care, an Associate Director of Care and 3 Registered Nursing Staff confirmed that the expectation is that families/SDM's are notified of a change in condition and given the opportunity to participate in decision making regarding treatment and intervention and could not confirm that Resident #001's Substitute Decision Maker was notified of a change in condition. [s. 6. (5)]

2. The licensee failed to ensure that that the plan of care is revised when the Resident's care needs change as evidenced by:
a) Record review revealed that Resident #001 had a change in condition.
b) Record review revealed the plan of care was not revised following a noted change in condition for Resident #001.
c) The Director of Care, an Associate Director of Care and 3 Registered Nursing Staff confirmed that the plan of care was not revised when Resident #001 was assessed as having a change in condition. [s. 6. (10) (b)]

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 Residents and/or Substitute Decision Makers have been provided an opportunity to participate fully in the development and implementation of the plan of care and that Residents are reassessed and plans of care are reviewed and revised when Residents' care needs change, to be implemented voluntarily.

Issued on this 22nd day of May, 2014

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