



**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**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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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
Sep 27, 2016	2016_303563_0031	027446-16	Resident Quality Inspection

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

MELANIE NORTHEY (563), DONNA TIERNEY (569)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 20, 21, 22 and 26, 2016

The following intakes were completed within the RQI:

013329-16 - 3045-000012-16 Critical Incident related to falls

015742-16 - 3045-000018-16 Critical Incident related to falls

016951-16 - IL-44861-LO Anonymous Complaint related to air temperatures

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Clinical Services, the Registered Dietitian, the Environmental Service Manager, the Life Enrichment Manager, eight Registered Practical Nurses, four Personal Support Workers, three family members and twenty residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Maintenance
Contenance Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Residents' Council
Skin and Wound Care**



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

- 1 WN(s)
- 0 VPC(s)
- 0 CO(s)
- 0 DR(s)
- 0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review of the "Heat Related Illness" Policy #05-12 last revised June 2015 stated, "As air temperature approaches 26 degrees Celsius or humidex greater than 30 degrees, increase the frequency of monitoring to hourly and across all three shifts."

Record review of the "Daily Temperature/Humidity Record" for May 2016 documented the air temperature and humidity readings in each resident home area (RHA). The humidex for relative humidity in the Victoria Park RHA documented on May 3 and 5, 2016, an air temperature of 27 degrees Celsius with a humidity reading of 60% which equalled a humidex of 33 degrees Celsius. On May 19, 24 and 26, the humidex reading was 31 degrees Celsius. There was no documented evidence that hourly monitoring was done when the humidex was greater than 30 degrees Celsius.

Record review of a "Memo" dated May 27, 2016 from the Administrator #101 stated, "temperatures and humidity must be taken as per policy every hour of every shift... policy states that any time the air temperature approached 26 degrees Celsius or humidex is greater than 30 degrees, monitoring must be done hourly until it returns to consistent safe temperatures. Therefore, anytime this happens you must initiate the tracking and hourly temperature recording."

Record review of the "Field Visit Report" by the Ministry of Labour dated July 19, 2016 stated, "ensure hourly readings are conducted once the trigger point is met and hourly readings are to continue until the reading drops below the trigger point."

On September 26, 2016 at 1450 hours, the Environmental Service Manager (ESM) shared that the Maintenance Aide (MA) never checked the "Humidex" chart for relative humidity to determine if hourly checks should be implemented for a humidex reading of greater than 30 degrees Celsius. The ESM could not provide hourly documentation from those days in May where the humidex was greater than 30 degrees Celsius. [s. 8. (1) (b)]



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Issued on this 27th day of September, 2016

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

Original report signed by the inspector.