



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des Soins  
de longue durée**

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

**Rapport d'inspection prévue  
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**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130 avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jun 13, 2019	2019_607523_0027	010742-19	Critical Incident System

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**Licensee/Titulaire de permis**

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

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

Henley Place  
1961 Cedarhollow Boulevard LONDON ON N5X 0K2

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

ALI NASSER (523)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 10 and 11, 2019.**

**This inspection was conducted for Critical Incident Intake Log #010742-19 Critical Incident System #3045-000022-19 related to a medication incident.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care and two Registered staff members.**

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

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

**3 WN(s)**

**2 VPC(s)**

**1 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>Légende</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. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations during inspection with the Administrator showed that the windows in the home opened more than 15 centimetres.

The Administrator said that they would be working to ensure the and windows would not open more than 15 centimetres.

During this inspection, this non-compliance was found to have a minimal risk/harm or potential for risk/harm for the residents, it was found in several locations in the home and had the possibility to impact more than the fewest number of residents. The home had no previous non-compliance in this area. [s. 16.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date related to a medication incident that involved a resident. The CIS showed that a specific resident received a double dose of a certain medication.

Clinical record review showed a physician order that directed staff to give a specific dose of the medication at a certain time.

Clinical record review showed a progress note on a certain date completed by a specific RPN indicating that the resident received double the dose of the specific medication.

A review of the home's investigation notes with the DOC showed that the specific RPN gave a second dose of the specific medication without check the Electronic Medication Administration Record (EMAR).

The DOC said in an interview that the specific RPN did not check the EMAR prior to administering the specific medication. The DOC said that the expectation was for the RPN to check the EMAR prior to administering the medication and to give the medication as specified by the prescriber. [s. 131. (2)]

***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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**



**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1). (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date related to a medication incident that involved a resident. The CIS showed that the resident received a double dose of a specific medication.

Clinical record review showed a progress note on a certain date completed by a specific RPN indicating the resident was given a specific medication two times.

A review of the home's investigation notes with the DOC showed that the specific RPN discovered the medication incident at a certain time and did not take any action to assess the resident, did not inform the RN or the Doctor about the incident until around three hours later.

The DOC said that the RPN discovered the incident but they did not take any action till three hours later when they were asked to do so. DOC said that the RPN put the resident at risk by not taking immediate action.

The DOC said that expectation was to assess the resident right away, take immediate action, inform the RN and the Physician for more directions. [s. 135. (1)]



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***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 every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.***

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Issued on this 13th day of June, 2019

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

**Original report signed by the inspector.**



**Ministry of Health and  
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**Ministère de la Santé et des  
Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.  
O. 2007, chap. 8

**Long-Term Care Homes Division  
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**Division des foyers de soins de longue durée  
Inspection de soins de longue durée**

**Public Copy/Copie du public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** ALI NASSER (523)

**Inspection No. /**

**No de l'inspection :** 2019\_607523\_0027

**Log No. /**

**No de registre :** 010742-19

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Jun 13, 2019

**Licensee /**

**Titulaire de permis :** Henley Place Limited  
200 Ronson Drive, Suite 305, TORONTO, ON,  
M9W-5Z9

**LTC Home /**

**Foyer de SLD :** Henley Place  
1961 Cedarhollow Boulevard, LONDON, ON, N5X-0K2

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Melanie Smith

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To Henley Place Limited, you are hereby required to comply with the following order(s)  
by the date(s) set out below:





**Ministry of Health and  
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O. 2007, chap. 8

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**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

**Order / Ordre :**

The licensee must be compliant with O. REG. 79/10, s. 16  
Specifically, the licensee must:

- a) Complete an audit on all windows in the home to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened in any way more than 15 centimetres.
- b) A record of this audit shall be kept.

**Grounds / Motifs :**



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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.  
O. 2007, chap. 8

1. 1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents could not be opened more than 15 centimetres.

Observations during inspection with the Administrator showed that the windows in the home opened more than 15 centimetres.

The Administrator said that they would be working to ensure the and windows would not open more than 15 centimetres.

During this inspection, this non-compliance was found to have a minimal risk/harm or potential for risk/harm for the residents, it was found in several locations in the home and had the possibility to impact more than the fewest number of residents. The home had no previous non-compliance in this area. [s. 16.] (523)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

Jun 21, 2019



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
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**REVIEW/APPEAL INFORMATION**

**TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:



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O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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O. 2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603



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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.  
O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 13th day of June, 2019**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Ali Nasser

**Service Area Office /**

**Bureau régional de services :** London Service Area Office