Ontario

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2019	2019_788721_0025	007664-19	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

MEAGAN MCGREGOR (721)

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): July 17, 18 and 19, 2019.

The following Complaint intake was inspected during the course of this inspection:

Complaint IL-65805-LO/IL-65854-LO/Log #007664-19 related to concerns regarding staffing levels in the home and residents care needs not being met.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Program Manager, a Corporate Consultant, two Registered Practical Nurses (RPN's), six Personal Support Workers (PSW's) and several residents.

The Inspectors also observed residents and the care provided to them by staff throughout the home, reviewed clinical records and plans of care for identified residents and reviewed staff schedules for each home area.

Inspector Rhonda Kukoly (#213) was also present on July 17, 18 and 19, 2019, conducting concurrent Critical Incident System Inspection #2019_788721_0026.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person simultaneously assisted more than two residents needing total assistance with eating and that no resident who required assistance with eating was served a meal until someone was available to provide them with the assistance they required.

The Ministry of Health and Long-Term Care (MOHLTC) Action Line received complaint IL-65805-LO on a specific date, in which an anonymous complainant reported concerns of resident's care needs not being met due to the staffing levels in the home. During a discussion with the complainant on a later date, they reported that they still had concerns with the staffing levels in the home and residents being served cold meals as there weren't enough staff members to feed everyone.

Inspector #721 observed the following during meal service in a specific home area dining room throughout the course of the inspection:
- On a specific date and time there were six residents in the dining room and two residents in the adjacent family room observed to be requiring assistance with eating. Residents #013, #014, and #016 were receiving individual assistance with eating by visitors. Four PSW's were present in the dining room, one feeding residents #005 and #011, one feeding resident #012, one feeding residents #015 and #017 and one serving food.
- On a specific date and time there were seven residents in the dining room observed to be requiring assistance with eating. Two PSW's were present in the dining room, one feeding residents #014, #015, #016 and #017 and one serving beverages and providing resident #011 assistance with eating. Residents #012 and #013 had food sitting in front of them and there were no staff members present to provide them with assistance. Ten minutes later the PSW serving beverages and offering resident #011 assistance with eating was called to assist in another dining room and left, leaving one PSW in the dining room who was feeding residents #014, #015, #016 and #017. Four minutes after this another PSW came to the dining room and sat down to start feeding residents #012 and #013. Resident #005 was not present in dining room for this meal.
- On a specific date and time there were eight residents in the dining room observed to be receiving assistance with eating. Resident #014 was receiving individual assistance with eating by a visitor. Four PSW's and one life enrichment staff member were present in the dining room, one feeding resident #005, one feeding residents #012 and #013, one feeding residents #015, #016 and #017, and two serving food and beverages. Ten minutes later one of the PSW's who had been serving food sat down and started feeding

resident #011. Five minutes after this resident #017 was sitting with food in front of them and no staff members were providing them with assistance. Four minutes after this a PSW stopped feeding residents #015 and #016 and walked around the table to start feeding resident #017, then returned to feeding residents #015 and #016.
- On a specific date and time there were seven residents in the dining room observed to be requiring assistance with eating. Three PSW's were present in the dining room, one serving food and two serving beverages. Six minutes later residents #014, #015, #016 and #017 had food sitting in front of them and there were no staff members present to provide them with assistance. Two minutes after this one PSW stopped serving beverages and sat down to start feeding residents #012 and #013. Two minutes after this one PSW stopped serving food and sat down to start feeding resident #014 and #015 while residents #016 and #017 were still sitting with food in front of them and there were no staff members present to provide them with assistance. Four minutes after this the PSW feeding residents #014 and #015 walked around the table to start feeding resident #016 and #017, then returned to feeding residents #014 and #015. Thirteen minutes after this a second PSW sat down to continue feeding residents #016 and #017. Resident #011 was offered encouragement with eating through meal service by the PSW serving. Resident #005 was not present in dining room for this meal.

During meal service on a specific date and time RPN #101 told Inspector #721 that there were usually three PSW's scheduled in an identified home area dining room at meal service and that one PSW was responsible for serving food and two PSW's were responsible for feeding residents. RPN #101 stated that staff often had to feed multiple residents at once, especially at breakfast because visitors didn't come in to assist with feeding residents at breakfast like they did at lunch and dinner.

During meal service on a specific date and time RPN #101 informed Inspector #721 that additional help with transferring residents to the dining room and serving beverages was provided by the Registered Nurse (RN) and a student at that meal. Approximately one hour after the meal service had started in the dining room, RPN #101 stated that resident #005 had been fed their meal in their room by a management staff member five minutes prior. RPN #101 said that it was unusual for management staff to feed resident #005 in their room and that on days when resident #005 needs to eat in their room a PSW staff member was usually pulled from the dining room to assist them with eating in their room.

During meal service on a specific date and time PSW #113 told Inspector #721 that residents #014, #015, #016 and #017 required assistance with eating. PSW #113 stated that one PSW was responsible for feeding residents #014, #015, #016 and #017, except

for on days when the residents have visitors come assist them with eating.

During meal service on a specific date and time RPN #101 informed Inspector #721 that residents #005, #011, #012, #013, #014, #015, #016 and #017 in an identified home area dining room required staff assistance with eating. RPN #101 stated that additional help with feeding residents #005 and #011 was provided by a life enrichment staff member and PSW float at that meal.

During an interview on a specific date and time PSW #105 stated that there were supposed to be three PSW's in an identified home area dining room, one PSW would serve food and two PSW's were responsible for feeding eight residents. PSW #105 said that two residents usually have to wait to be fed while the PSW's feed two other residents. When asked if residents were ever served cold food because they had to wait to be fed, PSW #105 stated this happened the odd time depending on who served and that sometimes they had to ask staff to put the food back until they were done feeding someone else.

During an interview on a specific date and time, when asked if there were ever times when staff fed more than two residents at once, PSW #110 stated they usually fed four residents at once. PSW #110 stated they tried to seat residents who required feeding together so they could feed two residents and then bounce around the table and feed the other two. When asked if there were ever times when a resident who required assistance with eating was served food before a staff member was available to assist them, PSW #110 stated "oh yeah". When asked if these residents had ever been served cold food because of time they had to wait to eat, PSW #110 said "yep".

During an interview on a specific date and time, when asked how many residents each staff member should be responsible for feeding at the same time, Administrator #100 stated they shouldn't be feeding more than two residents at the same time.

Administrator #100 stated that if there weren't enough staff members available to feed all residents who required assistance with eating, they would expect the RN on duty to be notified and they would call life enrichment staff for additional help. When asked if they would expect residents who required assistance with eating to be served food if a staff member was not available to feed them at that time, Administrator #100 said "no, absolutely not".

The licensee failed to ensure that no person simultaneously assisted more than two

residents who needed total assistance with eating and that no residents who required assistance with eating were served a meal until someone was available to assist them as required on two occurrences on a specific date, and one occurrence on a second consecutive date. [s. 73. (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 no person simultaneously assists more than two residents who need total assistance with eating or drinking and no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

Issued on this 23rd day of July, 2019

[redacted]

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

Original report signed by the inspector.