Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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

Division des opérations relatives aux 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
Feb 17, 2021	2021_790730_0003	024724-20, 024726-20, 025259-20, 025705-20, 025856-20, 001947-21	Critical Incident System

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

CHRISTINA LEGOUFFE (730), ALI NASSER (523), KRISTEN MURRAY (731)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 1, 2, 3, 4, 5, 8, 9, and 10, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #025705-20, CIS #3045-000048-20 and Log #025856-20, CIS #3045-000050-20 were related to resident to resident abuse;

Log #024724-20, CIS #3045-000044-20 and Log #024726-20, CIS #3045-000045-20 were related to falls prevention and management;

Log #025259-20, CIS #3045-000046-20 was related to prevention of abuse and neglect;

and Log #001947-20, CIS #3045-000004-21 was related to outbreak management.

NOTE: A Compliance Order related to LTCHA s. 20 (1) was identified in this inspection and has been issued in a concurrent inspection, #2021_790730_0004.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Dietary Consultant, the Environmental Supervisor, Dietary Aides (DAs), the Director of Behaviour Supports, the Business Manager, Assistant Directors of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **2 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that one to one monitoring was provided to a resident as specified in their plan of care.

A resident showed an inappropriate behaviour towards another resident. At the time of the incident the aggressor was not being monitored as laid out in their plan of care. On another date, Inspector #730 observed that the resident was not being monitored as specified in their plan of care. There was increased risk to residents as a result of the resident not being monitored as specified in their plan of care.

Sources: Observation of the resident; record review including the plan of care and progress notes; and interviews with the Director of Behaviour Supports and other staff. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of a COVID-19 outbreak.

A COVID-19 outbreak was declared by the Middlesex-London Public Health Unit at the home on January 30, 2021. The home did not report the outbreak to the Director until February 1, 2021.

Sources: Critical Incident Systems Report 3045-000004-21, and interviews with Administrator #100 and Director of Care #101. [s. 107. (1) 5.]

Issued on this 17th day of February, 2021

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

Original report signed by the inspector.