Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: November 9, 2023

Inspection Number: 2023-1473-0006

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Henley Place Limited

Long Term Care Home and City: Henley Place, London

Lead Inspector	**Inspector Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2023.11.23 10:27:48 -05'00'

Additional Inspector(s)
Debbie Warpula (577)
Meagan McGregor (721)
Ali Nasser (523)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12, 13, 16, 18, 19, 20, 23, 24, 25, 30, 31, 2023 and November 1, 2, 2023.
The inspection occurred offsite on the following date(s): October 17, 25, 2023.

The following intake(s) were inspected:
Intake: #00092634 - CIS #3045-000050-23, related to the unexpected death of a resident,
Intake: #00092745 - Complaint related to multiple resident care concerns,
Intake: #00094002 - CIS #3045-000054-23, related to the falls prevention and management program,
Intake: #00094239 - CIS #3045-000055-23, related to the Improper/Incompetent treatment of a resident,
Intake: #00095122 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) Duty to protect,
Intake: #00095123 - Follow-up #: 1 - O. Reg. 246/22 - s. 56 (2) (a) Continence care and bowel management,
Intake: #00095124 - Follow-up #: 1 - O. Reg. 246/22 - s. 56 (2) (b) Continence care and bowel management,
Intake: #00095125 - Follow-up #: 1 - FLTCA, 2021 - s. 25 (1) Prevention of Abuse and Neglect,
Intake: #00095252 - CIS #3045-000058-23, related to the alleged neglect of a resident,
Intake: #00095633 - Complaint related to multiple resident care concerns,
Intake: #00096949 - CIS #3045-000065-23, related to a declared outbreak,

Intake: #00097181 - CIS #3045-000066-23, related to alleged staff to resident neglect,
Intake: #00098247 - Complaint related to resident care concerns and staff discipline,
Intake: #00100579 - CIS #3045-000092-23, related to staff to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #Duty to protect from Inspection #2023-1473-0005 related to FLTCA, 2021, s. 24 (1) inspected by Ali Nasser (523)

Order #002 from Inspection #2023-1473-0005 related to O. Reg. 246/22, s. 56 (2) (a) inspected by Ali Nasser (523)

Order #003 from Inspection #2023-1473-0005 related to O. Reg. 246/22, s. 56 (2) (b) inspected by Ali Nasser (523)

Order #001 from Inspection #2023-1473-0005 related to FLTCA, 2021, s. 25 (1) inspected by Ali Nasser (523)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Rational and Summary:
The home submitted a critical incident system (CIS) report related to a resident incident.

A clinical record review of the resident's plan of care documented two sets of specific directions different from each other for staff to follow when caring for the resident.

Interviews with management and staff supported the two sets of differing directions for staff should have been reviewed and updated when the resident's care needs changed to ensure there was one set of directions that provided a consistent and accurate reflection of the resident's care needs.

Sources: clinical record review, staff and resident interviews. [523]

Date Remedy Implemented: October 31, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident.

Rational and Summary:

A review of the resident's plan of care documented differing sets of directions for staff to follow when providing care to the resident, impacting the way the resident received care and putting the resident at risk of improper and unsafe care.

Interviews with management and staff supported the differing and multiple sets of directions documented in the resident's plan of care was unclear and should have been reviewed and updated to ensure the directions for staff were clear.

Sources: clinical record reviews, observations, and staff interviews. [523]

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

The licensee failed to ensure their required pain management program strategies, such as pain assessments, progress note documentation, and the use of as needed (PRN) pain medications were implemented for a resident.

The Ministry of Long-Term Care (MLTC) received a complaint related to multiple care concerns for a resident.

Rationale and Summary:
A clinical record review for a resident documented they were experiencing pain and were receiving regularly scheduled pain medication. The resident also had multiple orders for as needed (PRN) pain medications. The resident had several documented expressions of pain for which there were no associated pain assessments completed, and only one associated progress note to document the resident’s expressed pain and the registered staff’s implementation of strategies to manage the resident’s pain. Of the PRN pain medication orders available only one was administered and only some of the time. The lack of pain assessments, follow through to document the resident’s expressions of pain, and implementation of pain management strategies increased the resident’s risk of, and impacted the resident’s right to have their pain managed effectively for optimal care and comfort.

Sources: Resident clinical records, interviews with staff and management. [740]

WRITTEN NOTIFICATION: Weights

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to ensure that a resident's weight was measured and recorded monthly.

Rational and Summary:
A clinical record review documented a resident's weight to be measured at a certain interval, which was not followed.

Management said they expected the resident's weight to be measured and recorded and this was not done consistently. This put the resident at risk of missed weight changes and any interventions from being implemented by staff as needed.

Sources: record reviews and staff interview. [523]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the home's Infection Prevention and Control Program (IPAC) when a resident's personal items were not managed effectively by the home.

The Ministry of Long-Term Care (MLTC) received a complaint related to several care concerns involving a resident.

Rationale and Summary:
Observations and interviews with staff and management supported the resident's shared space had many personal items that were not managed and separated as per IPAC practices, potentially impacting the resident's health and increasing their risk of cross contaminated acquired infection..

Sources: Observations of a resident's space, interviews with staff and management. [740]

WRITTEN NOTIFICATION: Medication Management System

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that their written policies and protocols as part of their medication management system were implemented for a resident when,
A) A medication order was not processed as per the home's policy, and
B) A new medication order was not re-ordered before the previous orders were discontinued.

The Ministry of Long-Term Care (MLTC) received a complaint concerning medication administration for a resident.

A) A review of the resident's clinical records and interviews with management supported the resident had pain and was receiving regularly scheduled pain medications. A new medication order was received, which was not reviewed or processed as per the home's policy. This put the resident at actual risk of a medication incident as the accuracy of the orders and a more streamline set of medication orders were never established.

B) A review of the resident's clinical records and interviews with management supported the resident had multiple regularly scheduled pain medications with the same discontinuation date. The pain medication was not re-ordered before the previous pain medication orders were discontinued. This impacted the resident's rights and put the resident at risk of pain mismanagement.

Sources: Resident clinical records, the home's medication incident records, the home's "Ordering and Receiving Medications" and "Medication Reconciliation" policies, and interviews with staff and management. [740]

COMPLIANCE ORDER CO #001 plan of care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order FLTCA, 2021 s. 6 (7):

The licensee shall:

A) Ensure a resident's weight is taken as ordered.

B) The Registered Nurse (RN) will complete a daily audit within which they will monitor and ensure a resident's weight is taken as ordered. The audit must include the date and time the audit was completed, the name of the RN completing the audit, if the weight was completed or not and action taken by the RN. The audit must continue until the order has been complied by an inspector.

Grounds
The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rational and Summary:
A clinical record review for a resident documented the resident had a health condition which required intervention through monitoring of their weight at a certain interval and this was ordered by the resident's Nurse Practitioner.

Further review and interviews with management supported the resident's weight was not measured as ordered and should have been to prevent the potential risk of decline in the resident's health condition.

Sources: Clinical record review and staff interviews. [523]

This order must be complied with by November 24, 2023

COMPLIANCE ORDER CO #002 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order FLTCA, 2021 s. 24 (1):

The licensee shall:
A) Develop and implement a process that will identify who is responsible for receiving resident's lab results, reviewing the lab results, when and how to communicate those results to the physician.

B) Provide training to all staff members identified in the above process. A documented record must be maintained of the training provided, which includes the content of the training, date the training was

provided, and who attended the training.

C) Provide face to face training to all staff that provide direct care to residents on prevention of abuse and neglect.

D) A documented record must be maintained of the training provided, which includes the content of the training, date the training was provided, and who attended the training.

Grounds
The licensee has failed to ensure that,
A) A resident was not neglected by staff and,
B) A resident was protected from neglect, and verbal and emotional abuse by staff.

A) **Rational and Summary:**
O.Reg. 246/22 s. 7. Stated “For the purposes of the Act and this Regulation,
“neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

The home submitted a critical incident system (CIS) report related to abuse and neglect of a resident. A clinical record review and interviews with management supported the resident had a health condition requiring intervention. The results of the intervention were not shared immediately with the resident's physician which impacted and delayed the resident's treatment plan, putting the resident at risk of medical complications related to their health condition.

B) **Rational and Summary:**
O.Reg. 246/22 s. 2. (1) stated “for the purposes of the definition of “abuse” in subsection 2 (1) of the Act,
“emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.
“verbal abuse” means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.”

The home submitted a critical incident system (CIS) related to staff to resident abuse and neglect.

A review of the clinical records for the resident and interviews with management supported the resident

was abused and neglected by staff. The resident's right to freedom from abuse and neglect was impacted and put the resident at risk of injury.

Sources: Clinical record reviews and staff interviews. [523]

This order must be complied with by December 15, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued during inspection #2023_1473_0005 under FLTCA 2021 s. 24 (1).

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Skin and wound care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must,

A) Re-educate all registered nursing staff on which skin and wound care assessment tool should be used when documenting an initial skin and wound assessment and a weekly skin and wound assessment.

B) Re-educate all registered staff on how to properly assess pressure injuries, including but not limited to, accurate wound measurements, including but not limited to, depth and the documentation of wound tissue characteristics such as, type of tissue, colour, temperature, and odour.

C) The skin and wound care lead or designate will maintain an audit, within which they will monitor and review 2 residents' skin and wound care assessments from each home area each week, a total of 12 residents a week, to ensure the appropriate skin and wound care assessment tool is being implemented, that pressure injuries are being assessed, including measurements and wound tissue characteristics are documented, and that weekly wound assessments are being completed weekly. The audit must continue until the order has been complied by an inspector.

D) Keep a record,

1. Of the registered staffs re-education, including, the completion date of the education, the content of the education, a staff attendance signature list, and the name of the individual providing the re-education.
2. Of the skin and wound care lead or designee's audit.

Grounds

The licensee failed to ensure when multiple residents were exhibiting altered skin integrity, their wounds were reassessed at least weekly by a member of the registered nursing staff.

A) The Ministry of Long-Term Care (MLTC) received a complaint related to multiple care concerns, including the home’s implementation of their skin and wound care management program for a resident.

Rationale and Summary:

A clinical record review for a resident documented the resident exhibited various forms of altered skin integrity and their weekly wound assessments were not completed consistently each week, nor were the assessments completed using a clinically appropriate assessment tool. This impacted the resident's

right to appropriate monitoring of their wounds to meet their care needs and put the resident at risk of developing wound new areas of altered skin integrity .

Management said the resident's areas of altered skin integrity were not consistently assessed weekly using a clinically appropriate skin and wound assessment tool, and should have been.

Sources: Resident record review, and interviews with staff and management. [740]

B) **Rational and Summary:**

A clinical record review for a resident documented the resident had areas of altered skin integrity, requiring intervention for an associated health condition, and weekly wound assessments. The weekly wound assessments were not completed weekly and were not completed using a clinically appropriate assessment tool.

An interview with management supported the resident had altered skin integrity with an associated health condition and they would have expected staff to complete the weekly wound assessments using a clinically appropriate assessment tool to reduce the impact on the resident's health condition and risk complications.

Sources: Clinical record review and staff interviews. [523]

This order must be complied with by December 8, 2023

COMPLIANCE ORDER CO #004 Medication Administration

NC # Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must,

A) Re-educate all registered nursing staff on how, when and which members of the interdisciplinary team should be involved in the processing of new medication orders and the re-ordering of existing or discontinued medication orders.

B) Develop and implement a process to be completed by the medication management system lead or designate and then train all registered nursing staff on the developed process to ensure the monitoring of existing medication amounts and when staff are to re-order the residents' medications before the medication amounts run out or when the orders have been discontinued and an existing indication requires the resident to continue with the medication order.

C) Develop and implement a process to be completed by the medication management system lead or designate and then train all registered nursing staff on the developed process to ensure new medication orders are being processed by registered staff as per the home's policy and when registered staff should involve the interdisciplinary team to seek clarification of the medication orders, and to improve treatment plans to meet resident care needs.

D) Maintain a record of the developed and implemented processes in part A, B and C including, the training completed with the registered nursing staff on the developed processes, any coaching or disciplinary actions taken to correct any deficiencies, an attendance signature list, content of the education, the name of the person providing the re-education and the date on which the re-education was provided.

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

A) The Ministry of Long-Term Care (MLTC) received a complaint related to medication administration concerns for a resident.

Rationale and Summary:
A clinical record review documented a resident had pain and had several orders for pain medication.

A clinical record review documented the resident's pain medication was often administered late which was not in accordance with the prescriber’s directions. This impacted the resident’s right to consistent symptom management and increased their risk of uncontrolled pain management.

Sources: Resident medical records and interviews with staff and management. [740]

B) **Rational and Summary:**
The home submitted a Critical Incident System (CIS) report related to medication administration concerns.

A clinical record review documented the resident had several medication orders. Some of the medication supplies ran out and were not re-ordered for several days, putting the resident at risk of their health conditions being mismanaged when their medications were missed for several days.

Management said the expectation was for medication supplies to be monitored and ordered in a timely

manner to ensure medications were not missed and were given as prescribed.

Sources: record reviews and staff interviews. [523]

This order must be complied with by December 8, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Compliance Order CO #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:
A CO was issued during inspection #2023_1473_0002 under FLTCA 2021 s. 140 (2).

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.