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

Public Report

Report Issue Date: January 16, 2025

Inspection Number: 2024-1473-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Henley Place Limited

Long Term Care Home and City: Henley Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2, 6-10, 13-16, 2025
The inspection occurred offsite on the following date(s): January 3, 8, and 13, 2025.
The following intake(s) were inspected:
• Intake: #00130974- A concern related to the medication administration and other care concerns.
• Intake: #00131737- A concern related to the care of the resident.
• Intake: #00132762 - A concern related to the care of the resident.
• Intake: #00132802/Critical Incident System (CIS) #3045-000094-24 - A concern related to fall prevention and management.
• Intake: #00133098 - A concern related to medication administration and food production.
• Intake: #00135066 - A concern related to alleged abuse of a resident.
• Intake: #00136171 - A concern related to the care of the resident.
• Intake: #00131391- A concern related to pest control in the home.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (a)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;

The licensee failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised when a goal in the plan was met.

A resident was diagnosed with a health condition and was administered medications for treatment and to prevent serious complications. The resident was monitored routinely as part of the plan of care. The resident had a goal that their health condition would be controlled through care and interventions. The care plan was cancelled on a specified date, and the goal was not met. The resident continued to receive care and interventions to manage their health condition.

The Director of Care stated the resident was receiving care and interventions to monitor and control their health conditions, but the resident would refuse monitoring and interventions. Therefore, the resident's health condition was not always controlled through care and interventions.

Sources: Review of medication administration records, the care plan, and progress notes for the resident, and interviews with the resident and Director of Care.

Date Remedy Implemented: January 7, 2025

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of care outlined in the plan of care for a resident was promptly and accurately documented.

A review of the Documentation Survey Report revealed inaccurate documentation of care provided on a specified date. Additionally, the staff did not record the information as closely as possible after delivering the care.

Sources: Clinical record reviews for the resident and an interview with the Director of Care.

WRITTEN NOTIFICATION: Complaints Procedure

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (b)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and

The licensee has failed to ensure that their written complaints procedure, for verbal complaints, included information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010, and to the Ministry.

O. Reg 246/22 s. 107 states that every licensee of a long-term care home shall ensure that the written procedures required under clause 26 (1) (a) of the Act incorporate the requirements set out in section 108 of the Regulation. Section 108 (1) 3 (i) of the Regulation states that responses made to a person who made a written or verbal complaint shall include the Ministry's toll-free telephone number for making complaints about homes, its hours of service, and contact information for the patient ombudsman.

A review of the Long-Term Care Home's written Complaints Procedure, the section for verbal complaints did not include any information related to providing the complaint with Ministry or ombudsman contact information.

Sources: Staff and complainant interviews, the Long-Term Care Home's Complaints Procedure.

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to the Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there was an allegation of resident-to-resident abuse it was immediately reported to the Director.

The Assistant Director of Care (ADOC) said this was something that should have been reported to the Director immediately.

Sources: Resident progress notes, interviews with the staff and ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's fall prevention and management program when staff did not complete quarterly fall risk assessments for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure that the written policies developed for the fall prevention and management program were complied with.

Specifically, the home's fall policy indicated that quarterly fall risk assessments were required for residents. The clinical record for the resident indicated the quarterly fall risk assessment was not completed within a specified period.

Sources: Resident clinical records, the home's "Falls Prevention & Management Program" policy, and an interview with the Associate Director of Care.

WRITTEN NOTIFICATION: Skin and Wound Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident who exhibited altered skin integrity received a Skin & Wound Evaluation, received immediate treatment and intervention, and was reassessed at least weekly.

A staff verified that the resident had a pressure ulcer, but no initial assessment was completed by a specified date, and no weekly assessments were conducted. The staff stated there was no electronic Treatment Administration Record (eTAR) to flag registered nursing staff to complete a weekly wound assessment for the resident's pressure ulcer. The lack of initial and weekly skin and wound assessments had the potential to increase the resident's risk for worsening altered skin integrity.

Sources: Clinical record review of skin assessments, progress notes, Treatment Administration Records for the resident, and interviews with the staff and Director of Care

WRITTEN NOTIFICATION: Altercations and other Interactions Between Residents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions to a resident by co-residents, by identifying factors and implementing interventions to ensure the resident's safety.

The resident was involved in multiple altercations by co-residents in a specified month. The licensee did not implement safety checks for the resident until a specified date and did not hold a care conference to identify factors and implement further interventions to ensure the resident's safety until concerns were raised by the inspector during the inspection.

Sources: Resident progress notes and plan of care, interviews with the Director of Care.

WRITTEN NOTIFICATION: Dining and snack service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

5. Food and fluids being served at a temperature that is both safe and palatable.

The licensee failed to ensure food and fluids were served at a safe and palatable temperature to the residents when the staff did not take or record temperatures at the point of service during a meal service on a specified date.

Additionally, multiple entries of meal service temperatures and snack cart beverages were not documented in the Food Temperature Point of Service Records between specified dates in certain home areas.

Sources: Review of Food Temperature Point of Service Records and an interview with the Food Service Manager.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1)

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. The response provided to a person who made a complaint shall include,

i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

ii. an explanation of,

A. what the licensee has done to resolve the complaint, or

B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that verbal complaints made to staff members concerning the care of a resident were properly addressed.

A family raised a concern about the care of a resident in the home. There was no evidence that the family's concerns were investigated or addressed. The family later contacted the relevant authorities as the issues had not been resolved.

Sources: Director of Care interview, POA interviews, and resident record review.

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A) The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

The resident was prescribed daily medications with instructions to monitor their vitals. However, the resident's vitals were not monitored before administering these medications. A staff stated they did not monitor the resident's vitals prior to administration.

B) The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

The Director of Care verified it was a medication incident and two tablets of the medication were administered to the resident instead of one as prescribed.

Sources: clinical record review of the Medication Administration Records and progress notes of the resident, Medication Incident Reports, observations, and interviews with the resident and Director of Care.

WRITTEN NOTIFICATION: Medication Incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (2)

Medication incidents and adverse drug reactions

s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,

(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

(b) corrective action is taken as necessary; and

(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee failed to ensure that all medication incidents were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything required.

A resident was prescribed a medication for administration at specific times on a particular day. The resident reported that both doses of the medication were administered at the same time. The Director of Care (DOC) verified that it was a

medication incident in which two tablets of the medication were administered to the resident instead of one tablet as prescribed. The DOC verified there was no written record of a medication incident report. The incident was not analyzed, and there was no corrective action taken with the staff member.

Sources: clinical record review of the Medication Administration Records and progress notes for the resident, Medication Incident Reports, and interviews with the resident and Director of Care.

COMPLIANCE ORDER CO #001 Plan of care

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Develop and implement an auditing tool related to personal hygiene and bed mobility care to ensure staff are providing care to the residents as specified in their plan of care.
2. Identify residents who require two staff for personal hygiene care in the home area.
3. Ensure the care plan interventions for those identified residents are being provided as planned.

Grounds

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

The resident was prescribed a nutritional supplement at specific times. Multiple sealed nutritional supplements were observed in the resident's room. A staff provided the resident with the supplement and signed the electronic Medication Administration Record (eMAR) as administered. The Director of Care stated that the administration of the supplement should be documented when it was consumed, not just that it was given to the resident.

The resident reported not being administered a nutritional supplement for a stretch of up to several days, and the resident documented that they did not receive the supplement at a specific time and that both doses were missed on other dates. The eMAR documented the supplement was administered at certain times, with discrepancies between the documented and actual administration. The eMAR also showed that the supplement was recorded as refused on specific dates. The resident stated they have never refused or declined the administration of the supplement and have a medical condition that required this intervention.

Monitoring the nutritional intake of the resident and assessing the effectiveness of nutritional interventions may be compromised when documentation inaccurately reflects administration, and the resident is not consuming the supplements.

Sources: clinical record review of dietary supplement orders, nutritional referrals, administration records for the resident, observations, and interviews with the resident, staff, and Director of Care.

B. The licensee failed to ensure that personal hygiene and bed mobility care set out in the plan of care were provided to a resident as outlined in their plan of care.

The resident was provided with personal hygiene care in bed by a staff member. However, the resident's care plan indicated that they required assistance from two

staff members for care. This created a risk of injury when the resident was left unattended during the care, resulting in a fall and fall-related injuries.

Sources: Critical Incident Investigation notes, the resident's plan of care, and an interview with the Director of Care.

This order must be complied with by February 21, 2025

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 #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, 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 compliance Order was Issued on November 9, 2023, during the inspection #2023-1473-0006 under FLTCA 2021 s. 6 (7)

This is the first 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.