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

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Public Report

Report Issue Date: April 2, 2025
Inspection Number: 2025-1393-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Henley House Limited
Long Term Care Home and City: The Henley House, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 26, 27, 28, 31, April 1 and 2, 2025.

The following intakes were inspected:

- Intake: #00134304 - Critical Incident (CI) related to the prevention of abuse and neglect.
- Intake: #00135389 - Complaint related to resident care and support services, continence care and pain management.
- Intake: #00136190 - Follow-up to compliance order #001 for O. Reg. 246/22 - s. 57 (2) from inspection #2024_1393_0006.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1393-0006 related to O. Reg. 246/22, s. 57 (2)

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident. A resident's plan of care had an order to complete a procedure as needed and under special instructions it stated not to complete the procedure as per their substitute decision-maker (SDM), this did not provide clear direction to staff.

Sources: A resident's clinical record and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Involvement of resident, etc

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's SDM was given an opportunity to participate fully in the development and implementation of the plan of care. On a specified date, the physician ordered a procedure to be completed and the SDM was not notified of the order or the procedure that was completed.

Sources: A resident's plan of care; investigation notes and interview with DOC.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcome of the care set out in the plan of care for a resident was documented. On a specified date a resident had a procedure performed as documented. Investigation notes from the home and interview with staff identified the resident responses during the procedure. Review of the progress notes did not include documentation that the resident consented to the procedure or how the resident tolerated the procedure or any follow-up care related to this.

Sources: A resident's clinical record and interview with the DOC and other staff.