

Ministry of Long-Term Care

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

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: June 24, 2025

Inspection Number: 2025-1393-0003

Inspection Type:

Complaint
Critical Incident

Licensee: Henley House Limited

Long Term Care Home and City: The Henley House, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6, 9-13, 16-17, 23, 2025

The inspection occurred offsite on the following date(s): June 19-20, 2025

The following intake(s) were inspected:

- Intake: #00130105, Critical Incident System (CIS) #2909-000124-24 related to prevention of abuse and neglect;
- Intake: #00142359, CIS #2909-000015-25 related to prevention of abuse and neglect;
- Intake: #00142790, CIS #2909-000018-25 related to prevention of abuse and neglect; and
- Intake: #00148155, complaint related to admission, absences and discharge.

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

Prevention of Abuse and Neglect
Admission, Absences and Discharge

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with when a staff member did not immediately report an allegation of abuse to a resident, as required by the home's policy. The Director of Care (DOC) acknowledged that the home's policy was not complied with.

Sources: A resident's clinical records; home's investigation notes; home's policy "ZERO Tolerance of Resident Abuse/Suspected abuse or Neglect," last revised December 2024, interview with a DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

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(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident was demonstrating responsive behaviours, medications were administered as intended.

Sources: A resident's clinical record and interviews with a Registered Practical Nurse (RPN) and Registered Nurse (RN).

WRITTEN NOTIFICATION: When licensee may discharge

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 157 (2) (b)

When licensee may discharge

s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The licensee has failed to ensure that prior to discharging a resident when they were absent from the home, they were informed by the resident's attending physician or a registered nurse in the extended class that their requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

A resident was sent to hospital and several days later, while in hospital, the home discharged the resident. The Executive Director (ED) acknowledged that the decision to discharge the resident was not informed by the resident's attending physician or a registered nurse in the extended class at the hospital.

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Sources: A resident's clinical record from the LTCH and hospital; interview with the ED and others.

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

The licensee has failed to ensure that before discharging a resident under subsection 157 (1), they collaborated with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident.

A resident was sent to hospital and several days later, was discharged from the home. A placement coordinator indicated there were no recent conversations regarding alternative arrangements for the accommodation, care and secure environment required by the resident prior to their discharge from the home, as confirmed by the ED.

Sources: A resident's clinical record; interview with the placement coordinator and the ED.

COMPLIANCE ORDER CO #001 Duty to protect

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NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Conduct an analysis of the incident of physical abuse that occurred..
2. Evaluate the results of the analysis.
3. Determine changes or improvements that are required as a result of the analysis.
4. Implement changes or improvements.
5. Maintain a written record of the results of the analysis, the changes or improvements that were identified and how they were implemented.

Grounds

The licensee has failed to protect a resident from physical abuse by a co-resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

An incident occurred where a resident caused an injury to a co-resident which resulted in a significant change in their health status.

Sources: Resident clinical records and interviews with a Personal Support Worker (PSW), RPN, RN and DOC.

This order must be complied with by July 15, 2025

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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 \$5500.00, 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 High Priority Compliance Order was issued to FLTCA 2021 s. 24 (1) on July 16, 2024 during inspection #2024-1393-0003. This was the only CO issued to this legislative reference in the past 36 months.

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

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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.

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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

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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

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Director

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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.