

Public Report

Report Issue Date: September 5, 2025

Inspection Number: 2025-1393-0005

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): August 22, 25, 26, 27, 28, 29, 2025, and September 2, 3, 4, 5, 2025

The following intake(s) were inspected:

- Intake #00149298/ Critical Incident (CI) #2909-000038-25 - related to safe and secure home
- Intake #00149922/ CI #2909-000041-25 - related to fall prevention and management
- Intake #00150617/ CI #2909-000044-25 - related to Infection Prevention and Control
- Intake #00151049/ CI #2909-000046-25 - related to resident care and support services
- Intake #00152284/ CI #2909-000050-25 - related to resident care and support services
- Intake #00154382/ CI #2909-000054-25 -related to resident care and support services
- Intake #00154668/ CI #2909-000057-25 - related to fall prevention and management
- Intake #00154734/ CI #2909-000056-25 - related to Infection Prevention and Control
- Intake #00155117 - complaint related to Infection Prevention and Control

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
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 (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 the resident set out clear directions to staff and others who provided direct care to the resident.

A Personal Safety Assistive Device (PASD) assessment specifically for the use of an assistive device was completed for a resident on a specified date. The assessment indicated the resident required a specific device to assist with bed mobility. The Point of Care (POC) documentation did not set out clear directions to staff and others who provided direct care to the resident.

The Director of Care (DOC) confirmed that the directions on POC should have reflected the content of the assessment on the date the PASD assessment was completed for the resident. On the same day, the POC task was updated.

Sources: Observations, the resident's clinical record, and an interview with the DOC.

Date Remedy Implemented: August 22, 2025

WRITTEN NOTIFICATION: Falls prevention and management

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

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Non-compliance with: O. Reg. 246/22, s. 53 (2) (a)

Required programs

s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,

(a) provide for screening protocols.

The licensee has failed to ensure that the falls prevention and management program was complied with when a screening protocol was not completed. Specifically, a registered staff member failed to complete a fall risk screening tool for a resident.

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

The home's policy titled, Fall Prevention and Management Program, last approved on July 30, 2025, stated that all residents will have a comprehensive falls assessment completed upon move-in, re-admission to the home, or when there is a change in condition.

On a specified date, a resident was ambulating independently without their assistive device in their room and experienced a fall. The resident was transferred to the hospital, where they underwent surgical intervention for a serious injury. Upon return, the resident required extensive assistance with activities of daily living due to the injury.

The Associate Director of Care (ADOC) acknowledged that the screening tool should have been completed when the resident returned from the hospital.

Sources: Resident's clinical record; home's Falls Prevention and Management policy (approved July 30, 2025), and an interview with the ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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

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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 failed to ensure that their falls prevention and management program provided strategies to reduce or mitigate falls for the residents, including the use of equipment, supplies, devices, and assistive aids.

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

The written description of the falls prevention and management program required the home to update the resident's care plan to include additional precautions or strategies to prevent harm following a fall incident.

A. On specified dates, a resident experienced falls while using their mobility device. The ADOC documented strategies intended to reduce or mitigate the risk of falls, which included the implementation of a specific device; however, the device was not put in place, and the care plan was not updated accordingly.

Sources: Observations, resident's clinical record, home's Falls Prevention and Management policy (approved July 30, 2025), and an interview with the ADOC.

B. On a specified date, a resident experienced a fall from their bed. The ADOC documented strategies intended to reduce or mitigate the risk of falls, which included the implementation of a specific device; however, the device was not put in place, and the care plan was not updated accordingly.

Sources: Observations; resident clinical record, homes' Falls Prevention and Management policy (approved July 30, 2025), and an interview with the ADOC.

C. On a specified date, a resident experienced a fall while ambulating in their room. A staff member documented strategies intended to reduce or mitigate the risk of falls, which included the implementation of a protective device; however, the protective device was neither offered to the resident nor put in place, and the care plan was not updated accordingly. The ADOC and a staff member acknowledged that the intervention should have been offered to the resident, followed by documentation of the

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resident's decision to accept or decline the intervention.

During the inspection, the ADOC confirmed that the intervention was implemented, and the plan of care was updated.

Sources: Observations; resident's clinical record, home's Falls Prevention and Management policy (approved July 30, 2025), interview with resident, the ADOC, and a staff member.

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that, following a fall incident, the resident received a post-fall assessment using a clinically appropriate assessment instrument specifically designed for falls, as required.

On a specified date, a housekeeping staff member observed the resident seated at the edge of their mobility device and alerted other staff. Staff assisted the resident to the floor to prevent a fall and subsequently used a mechanical lift to transfer the resident safely to their bed.

A registered staff member confirmed that the incident met the definition of a fall in accordance with the home's policy and that a post-fall assessment should have been completed. However, no such assessment was documented.

Sources: Resident's clinical record, home's Falls Prevention and Management Policy (approved July 25, 2025), and an interview with the registered staff.

WRITTEN NOTIFICATION: Dealing with complaints

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NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

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:

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,

The licensee has failed to ensure that the complaint response letters for written complaints concerning the care for a resident that were provided to the complainant during the specified dates, contained the correct toll-free telephone number, and hours of operation for making complaints about the home to the Ministry of Long Term Care.

The Director of Care (DOC) acknowledged that the response letters provided to the complainant at the specified times did not include the required information.

Sources: Critical Incident (CI) reports, complainant response letters, the home's investigation notes, and an interview with the DOC.

WRITTEN NOTIFICATION: Resident records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 274 (b)

Resident records

s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that the resident's written record was kept up to date when staff did not document an unsuccessful attempt to complete the prescribed medical intervention.

The DOC and a registered staff member acknowledged that the expectation was for documentation of any inability to complete the prescribed medical intervention in the electronic record of the resident so that the clinical team could reassess care needs as

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required.

Sources: Resident's clinical records, interview with the DOC, and registered staff member.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

A) Re-educate the identified staff and student on Personal Protective Equipment (PPE) procedures for residents on additional precautions, covering the selection, application, removal, and disposal of the required PPE.

B) Document the education, including the components of education, the date the education was provided, and the name of the staff member(s) who provided the education.

C) Conduct the PPE audits for the specified period of time for the identified staff and student to evaluate proper selection, application, removal, and disposal of the required PPE for residents on additional precautions.

D) Maintain written records of the audits for inspector review, including the date and time of an audit completion, the name of the staff member(s) who completed the audits, and corrective actions (if any) that were taken after completion of these audits.

Grounds

A) The licensee has failed to ensure that the "Infection Prevention and Control Standard for Long-Term Care Homes, September 2023" (IPAC Standard) was implemented. The IPAC Standard under section 9.1, related to Additional Precautions, subsection (f) stated that the licensee shall ensure that at minimum, additional precautions shall include, additional PPE requirements, including appropriate selection, application,

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removal, and disposal.

An additional precaution signage posted at the resident's room door instructed all personnel to wear specific PPE before entry. On an identified date, a Personal Support Worker (PSW) student was observed inside the resident's room without the required PPE. The PSW student also did not follow the correct PPE donning and doffing sequence as outlined on the signage.

The Home's Director of Care (DOC) confirmed that PSW students are expected to follow the home's PPE policies and procedures.

The improper selection, application, removal, and disposal of PPE by the PSW student created a risk of spreading infectious diseases to the resident and others in the home.

Sources: Resident's room observation, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes Standard (last revised - September 2023), and an interview with the DOC.

B) The licensee has failed to ensure that the "Infection Prevention and Control Standard for Long-Term Care Homes, September 2023" (IPAC Standard) was implemented. The IPAC Standard under section 9.1, related to Additional Precautions, subsection (f) stated that the licensee shall ensure that at minimum, additional precautions shall include, additional PPE requirements, including appropriate selection, application, removal, and disposal.

An additional precautionary signage at the entrance of the resident room required staff to wear specific PPE upon entry. On an identified date, a PSW was observed inside the resident's room without the required PPE. The PSW admitted to not reviewing the additional precaution signage and PPE requirements for the resident. The PSW also reported that a specific PPE was unavailable due to the PPE cart not being replenished by staff on the previous shift.

By not adhering to the PPE requirements outlined on the additional precautions signage, the PSW potentially exposed the resident and others to the risk of infectious disease transmission.

Sources: Resident's room observation, Infection Prevention and Control (IPAC)

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Standard for Long-Term Care Homes Standard (last revised - September 2023), and an interview with PSW.

This order must be complied with by October 3, 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 \$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:

- O.Reg. 246/22, s. 102 (2)(b) - A Written Notification (WN) issued on 2025-07-30 under inspection #2025-1393-0004
- O.Reg. 246/22, s. 102 (2)(b) - A Compliance Order (CO) issued on 2024-06-03 under inspection #2024-1393-0001
- O.Reg. 246/22, s. 102 (2)(b) - A Written Notification (WN) issued on 2023-07-17 under inspection #2023-1393-0005

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

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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 #002 CMOH and MOH

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

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

- A) Ensure that the identified staff document the cleaning and disinfection of high-touch surfaces each time the task is completed. Documentation must include the date and time of task completion, as well as the name of the staff member who completed it.
- B) Re-educate all the identified staff on the procedure and frequency of cleaning and disinfection of high-touch surface areas during an outbreak.
- C) Document the education, including the component of the education, the date the education was provided, the name of the staff receiving education, and the name of the staff member (s) who provided the education.
- D) Maintain a written record of the education provided to the identified staff, for inspector review.

Grounds

The licensee failed to ensure that high-touch surfaces were cleaned and disinfected twice daily during a COVID-19 outbreak.

As of February 2025, the recommendations issued by the Chief Medical Officer of Health (CMOH) for Outbreak Prevention and Control in Institutions and Congregate

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Living Settings, section 3.12 for enhanced environmental cleaning and disinfection, recommended the minimum twice daily cleaning and disinfecting of high-touch surfaces for common areas, treatment areas, dining areas, and lounge areas.

A COVID-19 outbreak was declared at Henley House by Niagara Region Public Health on a specified date, and was later upgraded to a facility-wide outbreak. The home's policy required cleaning and disinfecting high-touch surfaces at least twice daily during an outbreak.

A review of records identified that staff did not clean and disinfect the high-touch surface areas twice daily during the COVID-19 outbreak, as required. Home's Environmental Services (EVS) Consultant acknowledged that staff did not clean and disinfect high-touch surface areas in multiple resident home areas according to the required cleaning and disinfection frequency during a confirmed COVID-19 outbreak.

There was an increased risk of infectious disease transmission to residents when the home staff did not follow procedures and CMOH recommendations for twice-daily cleaning and disinfection of high-touch surfaces during a confirmed COVID-19 outbreak.

Sources: Home's Policy titled "High Touch Surface Cleaning", CMOH Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (Effective: February 2025), High Touch Surface Cleaning Checklists for resident home areas, interviews with the staff, and EVS Consultant.

This order must be complied with by October 3, 2025

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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

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

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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.