

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

Hamilton District

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

Public Report

Report Issue Date: October 30, 2025 Inspection Number: 2025-1393-0006

Inspection Type: 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 date(s): October 23 to 24, 27 to 29, 2025.

The following intake(s) were inspected:

- -Intake #00156558/Critical Incident (CIS) #2909-000059-25 related to resident care and services,
- -Intake #00159074/CIS #2909-000069-25 related to infection prevention and control,
- -Intake #00157176 Follow-up #1 Compliance Order (CO) #001/ 2025-1393-0005, O. Reg. 246/22 s. 102 (2) (b), Compliance Due Date (CDD) October 03, 2025,
- -Intake #00157175 Follow-up #2 CO #002/ 2025-1393-0005, O. Reg. 246/22 s.
- 272, CDD October 03, 2025.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1393-0005 related to O. Reg. 246/22, s. 102 (2) (b) Order #002 from Inspection #2025-1393-0005 related to O. Reg. 246/22, s. 272

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

Resident Care and Support Services Infection Prevention and Control



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with complaints

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

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

The licensee failed to ensure that when a verbal complaint was made to a staff member regarding the care of a resident, a response was provided to the complainant within the specified number of business days after receiving the complaint.

Sources: Review of resident's clinical record and Home's complaint 7form; Interviews with staff.