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
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Public Report

Report Issue Date: March 19, 2025

Inspection Number: 2025-1473-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Henley Place Limited

Long Term Care Home and City: Henley Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7, 10, 11, 12, 13, 17, 19, 2025.

The following intake(s) were inspected:

- Intake #00133187 - Follow-up to compliance order (CO) from Inspection 2024-1473-0005 related to O. Reg. 246/22 - s. 79 (1) 5. Dining and Snack Service.
- Intake #00137388 - Follow-up to CO from Inspection 2024-1473-0006 related to FLTCA, 2021 - s. 6 (7) Plan of Care.
- Intake #00139638 / Critical Incident (CI) #3045-000010-25 was related to resident to resident abuse.
- Intake #00140667 / CI #3045-000012-25 was related to a resident fall.

The following intakes were also completed:

- Intake #00135841 / CI #3045-000100-24 and intake #00137366 / CI #3045-000004-25 were both related to resident falls.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1473-0005 related to O. Reg. 246/22, s. 79 (1) 5.
Order #001 from Inspection #2024-1473-0006 related to FLTCA, 2021, s. 6 (7).

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to quality care and self determination

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure that a resident's behavioural care needs were met when their responsive behaviour referral was not responded to for two weeks, since

this was not in a reasonable timeframe to provide the necessary care and services.

Sources: Resident electronic medical records, specifically progress notes and assessments, and interviews with the Director of Care (DOC) and the behavioural support (BSO) internal team.

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 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee failed to ensure that the home's internal behavioural supports team coordinated with the physician, pharmacist, music therapist, the management team, specialized services and or any other relevant individual or team to implement the home's responsive behaviours program. The lack of a coordinated approach failed to ensure a resident was supported through their responsive behaviours on an interdisciplinary basis.

Sources: Resident electronic medical records, specifically progress notes and assessments, and interviews with the Director of Care (DOC) and the behavioural support (BSO) internal team.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

The licensee failed to ensure that cognitive, environmental, social, emotional, physical or other behavioural triggers were identified when a resident was demonstrating frequent responsive behaviours.

Sources: Resident electronic medical records specifically, progress notes, and interviews with the Director of Care (DOC) and the internal behavioural support program team.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that actions were taken, including reassessments and interventions, and that resident's responses to the interventions were documented when a resident was demonstrating frequent responsive behaviours, including verbal and physical altercations with staff and other residents.

Sources: Resident electronic medical records, specifically progress notes, and

interviews with the Director of Care (DOC) and the behavioural support (BSO) internal team.