

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: June 13, 2025

Inspection Number: 2025-1473-0004

Inspection Type:

Critical Incident

Licensee: Henley Place Limited

Long Term Care Home and City: Henley Place, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, 2025

The following intake(s) were inspected:

- Intake: #00148306, related to improper care/treatment of a resident.

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's right

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:

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16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee failed to ensure a resident's right to proper care consistent with their needs was promoted.

Clinical record review for a resident and staff interviews and interview with the Director of Care "DOC" showed the staff did not provide proper care and inform the physician when the resident's specific test results were over the normal range.

Sources: resident's records and staff interviews.

WRITTEN NOTIFICATION: Administration of drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee had failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

Clinical record reviews for the resident and interview with the DOC showed a medication was discontinued for the resident. The staff did not discontinue the medication and it was administered to the resident for more doses. DOC confirmed that this had no negative impact on the resident.

Sources: resident's clinical records including physician orders, staff interview.