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

Public Report

Report Issue Date: April 21, 2026

Inspection Number: 2026-1473-0004

Inspection Type:
Complaint
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): April 7-10, 13-17, 20, 21, 2026
The inspection occurred offsite on the following date(s): April 10, 2026
The following intake(s) were inspected:

- Intake: #00167389 - CI #3045-000001-26 - Alleged Improper/Incompetent treatment of a resident.
- Intake: #00167916 - CI #3045-000002-26 - Fall of a resident resulting in injury.
- Intake: #00168656 - CI #3045-000004-26 - Alleged Improper care to a resident.
- Intake: #00170288 - A complaint regarding the care of a resident.
- Intake: #00174961 - CI #3045-000011-26 - Fall of a resident resulting in injury.
- Intake: #00176049 - A complainant regarding alleged neglect of a resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Continence Care
Recreational and Social Activities
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;

A continence assessment indicated the resident required a continence product for all shifts. However, the home's supply list and the continence card showed different products were required during the day and evening compared to the night. Staff confirmed the resident wore one product during the day and evening and a different product at night.
A new continence assessment was completed to reflect the resident's current needs.

Sources: Resident's clinical records; and the home's continence product Distribution List; interviews with the home's staff.

Date Remedy Implemented: April 17, 2026

NC #002 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;

The falls care plan stated the resident required staff assistance for walking, and fall prevention interventions were in place. An assessment later changed the resident's transfer status and updated the transfer focus and logo. However, the falls care plan was not updated and continued to indicate staff assistance, and the intervention remained in place. Leadership staff confirmed the care plan did not clearly reflect the resident's current needs and required review.
The plan of care was subsequently updated.

Sources: Resident's clinical records; and interviews with staff members.

Date Remedy Implemented: April 13, 2026

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital,

The resident experienced a fall and was transferred to hospital, where they were treated for an injury. The resident later returned to the home. The home's policy required registered staff to complete a head to toe assessment upon the resident's return from hospital. A review of clinical records showed this assessment was not completed as required.

Sources: Resident's clinical records; Skin and Wound Care policy; interview with staff members.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The resident experienced a fall and was transferred to hospital, where they were treated for an injury. The resident returned to the home following treatment. A review of clinical records showed that an initial skin and wound assessment, using an appropriate assessment tool, was not completed upon resident's return from hospital.

Sources: Resident's clinical records; Skin and Wound Care policy; interview with staff member.

WRITTEN NOTIFICATION: Missing personal clothing

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items;

A complaint was received regarding missing clothing items belonging to a resident. The home is required to have a process to report and locate missing resident

clothing, however, staff did not follow the home's policy for managing personal items as part of the laundry service. The missing items for resident were not located.

Sources: Complaint intake; review of home's policy; record review of resident; and interview with staff member.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
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,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief

A written complaint regarding a resident's care was received by the home. During an interview, leadership staff stated that the written response to the complainant did not include the actions taken to resolve the complaint or whether the complaint was considered unfounded, together with the reason for the belief.

Sources: Review of Critical Incident System Report; review of written complaint

from resident's Power of Attorney (POA); review of resident's clinical records; review of home's policy; and an interview with staff member.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

a) Review and revise the Zero Lift and Transfer Policy to clearly specify the roles and responsibilities of all staff members involved in the lift and transfer process.

b) Review and revise the Zero Lift and Transfer Policy to clearly indicate the roles of the Physiotherapist, registered nursing staff, PSWs, and restorative staff related to:
1) completion of lift and transfer assessments, and
2) care planning, including the selection and documentation of appropriate sling and loop sizes.

c) Provide education to all registered nursing staff, Personal Support Workers (PSWs), nursing managers, restorative staff, and Physiotherapy staff involved in resident care regarding the policy updates identified in parts a) and b).

d) Complete a documented audit of all residents in the home who requires a mechanical lift to identify 1) whether lift and transfer assessment meets the home's updated policy requirements and 2) whether their lift and transfers plan of care meets the home's updated policy requirements. The documentations of the audit must include the list of residents audited, who completed the audit and the corrective actions taken based on the results of the audit.

e)The DOC or designate conduct a documented assessment for PSWs related to their individual safe lift and transfer techniques, including documentation of any corrective actions taken.

Grounds

Staff did not use safe lift and transfer techniques when assisting a resident. This contributed to an injury that required transfer to hospital, after which the resident passed away.

The home’s investigation identified gaps in lift and transfer assessments, care plan documentation, staff training, and related policies.

Leadership acknowledged that staff practices were unacceptable and did not follow required lift and transfer protocols. Staff also demonstrated limited recognition of safe mechanical lift and transfer principles.

Improper or inconsistent lift and transfer practices, unclear assessments, inadequate training, and unclear roles and procedures increase the risk of serious resident injury or death during mechanical lift transfers.

Sources: Record review of Critical Incident (CI); the home's CI investigation; resident's clinical records; the home's policy; and interviews with staff members.

This order must be complied with by May 29, 2026

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Long-Term Care Inspections Branch

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London, ON, N6A 5R2
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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

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
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.