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

Hamilton District
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Public Report

Report Issue Date: March 17, 2025

Inspection Number: 2025-1599-0002

Inspection Type:
Critical Incident

Licensee: The Regional Municipality of Niagara

Long Term Care Home and City: Douglas H. Rapelje Lodge, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 10-14, and 17, 2025.

The following Critical Incident (CI) intakes were inspected:

- Intake: #00132833/CI M604-000014-24 was related to prevention of abuse and neglect; and,
- Intake: #00139642/CI M604-000007-25 was related to falls prevention and management.

The following intake was completed:

- Intake: #00129225/CI M604-000013-24 was related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when their needs changed. An intervention in the resident's care plan specified how their assistive device was to be modified for safe mobility; however, the task for that intervention had been resolved. The home's Clinical Documentation and Informatics lead (CDI) stated that due to a change in the resident's ability, that modification was no longer necessary. When the CDI was informed that the resident's care plan was not revised to reflect the change, they deleted the information that was no longer applicable.

Sources: resident's clinical records; and interview with the CDI.

Date Remedy Implemented: March 11, 2025.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a head injury routine (HIR) assessment was documented for a resident as indicated in their plan of care and as per the home's policy. Registered staff suspected a possible head injury and initiated HIR assessments for a resident. Recorded vitals confirmed a registered practical nurse's (RPN) recollection that the resident was being monitored for a head injury; however, a review of HIR assessments showed that not all assessments were documented as per the home's policy.

Sources: resident's clinical records, Head Injury Routine (HIR) & Neurological Assessment (PCS04-003; November 18, 2024); and interview with an RPN.