Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: January 13, 2026
Inspection Number: 2026-1516-0001
Inspection Type: Critical Incident
Licensee: Foyer Richelieu Welland
Long Term Care Home and City: Foyer Richelieu Welland, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7, 8, 9, 12, 13, 2026

The following intake(s) were inspected:
- Intake #00165279/Critical Incident (CI) #3022-000003-25 - related to fall prevention and management

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain management

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The registered staff did not complete the required pain assessments after fall incidents that caused a significant change in the resident's health status.

The home's policy titled “Pain Management,” last revised in June 2025, required the registered staff to complete a comprehensive pain assessment when a resident experiences a fall. On specified dates, a resident sustained falls that resulted in a significant change in their health status.

A review of fall incident records indicated that the resident reported pain following the fall incidents. The Director of Care (DOC) acknowledged that registered staff did not complete the required post-fall pain assessments following the resident's fall incidents.

Sources: Resident's clinical records, Home's Policy titled "Pain management", last revised in June 2025, and an interview with the DOC.

COMPLIANCE ORDER CO #001 Falls prevention and management

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Educate and re-train all the registered staff on the home's Fall Prevention and Injury Reduction policy and procedure, including but not limited to registered staff's expectation of completing a post-fall assessment and an accurate fall risk assessment when a resident experiences a fall, as required by the home's policy.
B) Document and maintain written records of the education in the home, including the components of education, the date and time the education was provided, the name of the staff member(s) who provided the education, and the name of the staff member(s) who were educated.

Grounds

The registered staff did not complete post-fall assessments following fall incidents that resulted in a significant change in the health status of a resident.

On an identified date, a resident was admitted to the long-term care home and was independently ambulatory without mobility aids. Within a specified timeframe, the resident experienced multiple falls resulting in injuries and a significant decline in their ambulation.

A review of fall incident records identified that registered staff did not complete required post-fall assessments for the resident following multiple fall incidents. The

Home's Director of Care (DOC) and Falls Program Lead acknowledged that post-fall assessments were not completed, which resulted in the resident's fall risk status not being accurately updated and contributed to delays in implementing appropriate fall prevention and management interventions.

The resident's fall risk was not adequately mitigated when registered staff failed to complete required post-fall assessments following fall incidents that caused a significant change in the resident's health status, resulting in delayed implementation of appropriate fall prevention interventions.

Sources: Resident's clinical records, Home's Policy titled "Fall Prevention and Injury Reduction" last revised in June 2025, an interview with the Falls Program Lead, and the DOC.

This order must be complied with by February 20, 2026

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

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.