

Ministry of Long-Term Care

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

Hamilton District

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

Public Report

Report Issue Date: March 24, 2026

Inspection Number: 2026-1118-0001

Inspection Type:

Critical Incident

Licensee: Niagara Health System

Long Term Care Home and City: Niagara Health System, Welland Hospital Site,
Extended Care Unit, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18 - 19, 23 - 24, 2026.

The following intake(s) were inspected:

-Intake: #00170915- Critical Incident (CI) #2607-000001-26 - related to prevention of abuse and neglect.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

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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) (a)

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,

(a) the planned care for the resident;

A resident was identified to have an alteration to their skin integrity and received a treatment that put them at risk for the alteration. A written plan of care that set out the planned care to minimize this risk was not in place.

During the inspection, their plan of care was updated.

Sources: Review of a resident's written plan of care, and an interview with the Administrator.

WRITTEN NOTIFICATION: Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

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(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident was identified to have an alteration to their skin integrity. A skin assessment by a staff member on a specified date indicated the alteration was present. A skin observation by another staff member on the same date indicated there were no skin alterations.

It was confirmed staff had not collaborated with each other in the assessment of the resident.

Sources: A resident's clinical records, and an interview with the Administrator.