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: July 24, 2025
Inspection Number: 2025-1477-0004
Inspection Type: Complaint Critical Incident
Licensee: 859530 Ontario Inc. (operating as Jarlette Health Services)
Long Term Care Home and City: Royal Rose Place, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11, July 14-18, and July 22-24, 2025

The following intake(s) were inspected:

- Intake: #00145692/Critical Incident (CI) #3049-000024-25 - related to falls prevention and management.
- Intake: #00146989/CI #3049-000028-25 - related to falls prevention and management.
- Intake: #00147940/CI #3049-000029-25 - related to alleged improper/incompetent treatment of a resident.
- Intake: #00148721/CI #3049-000034-25 - related to falls prevention and management.
- Intake: #00149627 - Complaint related to continence care and the prevention of abuse and neglect.
- Intake: #00149940/CI #3049-000037-25 -related to the prevention of abuse and neglect.
- Intake: #00150610/CI #3049-000040-25 - related to alleged improper/incompetent treatment of a resident.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident had their falls prevention intervention in place as specified in their plan of care.

On a specified date, inspector observed a resident using their assistive device without their falls intervention in place. The plan of care indicated the intervention was required when using the device. Staff confirmed the intervention was not in place.

Sources: Observations on a specified date; a resident's plan of care; interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident had an individualized plan to promote and manage their bowel and bladder continence.

A resident was assessed as being incontinent and would request assistance with toileting occasionally. Staff stated the resident had not been toileted for a period of time during a shift and that they would ask for assistance if needed. Staff then checked the resident following an interview with the inspector and found the resident incontinent. The resident did not call for staff assistance.

There was no individualized toileting plan in place to ensure the resident had sufficient checks and changes to remain clean and dry.

Sources: Observations on a specified date; a resident's plan of care; the home's LTC Continence Care and Bowel Management Program; interviews with staff.