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

Public Report

Report Issue Date: October 23, 2025
Inspection Number: 2025-1167-0003
Inspection Type: Critical Incident
Licensee: Maryban Holdings Ltd.
Long Term Care Home and City: Oakwood Park Lodge, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21, 22, 23, 2025.

The following intake(s) were inspected:
-Intake: #00158688 - Critical Incident (CI) #2661-000012-25 - related to falls prevention and management.

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

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

A) The licensee has failed to ensure that the staff collaborated with each other when

conducting specified assessments for a resident, so that their assessments were integrated and consistent with and complemented each other.

A resident had an incident that resulted in a significant change to their health status. Prior to this incident, they had several similar incidents.
The resident had diagnoses that put them at risk for the incidents to occur.

Over time, several specified electronic assessments had been conducted. It was noted that the assessment had not calculated the outcome accurately; however, the assessments contained a section that if answered, automatically provided the assessor with the outcome. Despite this, staff had not ensured their assessments were integrated, consistent and complimented each other.

Sources: a resident's assessments, and interviews with the Director of Care (DOC) and the Program lead.

B) The licensee has failed to ensure that the staff collaborated with each other when conducting specified assessments for a resident so that their assessments were integrated and consistent with and complemented each other.

An admission assessment for the resident indicated they were assessed to have a specified risk.

The resident had several instances in which this specified risk remained current. During these instances, several different assessments were conducted that asked about the risk identified on their admission. Many of these assessments indicated the resident was not at risk and one of these assessments had not answered the risk question and was left blank.

Sources: a resident's admission assessment, other assessments completed over time, and interviews with the DOC and a program lead.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 failed to ensure that when a resident sustained a significant change in their health status, their plan of care was reviewed and revised.

At the time of this inspection, the resident was unable to do certain activities of daily living and use specific equipment.

Review of a specific section of their current plan of care indicated staff were to encourage the resident to do these actions; that the resident would use the specified equipment in certain situations, and an intervention was put into place for the resident that had not been included in their plan of care.

Sources: a resident's plan of care, including care plan, Kardex, tasks in Point Click Care, progress notes, and interview with the DOC and a program lead.