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: July 7, 2025
Inspection Number: 2025-1490-0004
Inspection Type: Critical Incident Follow up
Licensee: The Governing Council of the Salvation Army in Canada
Long Term Care Home and City: R. H. Lawson Eventide Home, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 4 and 7, 2025.

The following intakes were inspected:

- Intake #00146868 - Follow-up to High Priority CO #001/2025_1490_0003, FLTCA, 2021 - s. 6 (7) Plan of care.
- Intake #00148194 [Critical Incident Report #2991-000011-25] - Prevention of Abuse and Neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1490-0003 related to FLTCA, 2021, s. 6 (7)

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

Prevention of Abuse and Neglect
Staffing, Training and Care Standards

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 failed to ensure that a resident was checked by staff every 1-2 hours for toileting needs, as specified in their plan of care. The resident sustained minor skin impairment as a result of this non-compliance, and was at risk for further skin breakdown, pain, and discomfort.

Sources: Resident's written care plan, Kardex, and assessments, Critical Incident Report (CIR), The home's investigation notes pertaining to CIR, and interviews with resident and staff.

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