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: September 10, 2025
Inspection Number: 2025-1490-0005
Inspection Type: Complaint Critical Incident
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 date(s): August 27-29, 2025, September 2-5, and September 8-10, 2025

The following intake(s) were inspected:

- Intake: #00151490/Critical Incident (CI) #2991-000014-25- Related to the prevention of abuse and neglect.
- Intake: #00152315- Complaint with concerns related to safe and secure home, plan of care, and administration of drugs.
- Intake: #00152336/CI #2991-000015-25- Related to falls prevention and management.
- Intake: #00155550- Complaint with concerns related to the prevention of abuse and neglect and resident care and support services.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Based on assessment of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure that a resident's plan of care was based on an assessment of the resident.

A resident was involved in an incident while being transferred. An assessment of the resident indicated they required a specific level of assistance for transfers. The resident's plan of care did not match the assessment and the resident was transferred using the incorrect level of assistance. Staff stated the assessment was not transferred into the plan of care and that staff would not have been aware of the change.

Sources: A resident's plan of care; interviews with staff.

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

The licensee has failed to ensure that a resident's assessment and plan of care were consistent and complemented each other.

Documentation in a resident's plan of care indicated the resident would not be a candidate for a transfer intervention. The resident's plan of care indicated staff were to use the transfer intervention, however there were no assessments indicating the resident was assessed to safely use the transfer intervention. Management acknowledged the inconsistency between the documentation and the plan of care would be confusing to staff.

Sources: A resident's plan of care; No Lift Policy; interviews with staff and management.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that when a resident refused care, it was documented in their plan of care.

On a specified date, a resident was involved in an incident and was found to be incontinent. The home's investigation notes indicated the resident refused personal care prior to the incident. A review of the resident's plan of care showed no documentation that the resident refused personal care and registered staff stated they were not made aware that the resident refused care.

Sources: A resident's plan of care; the home’s investigation notes; POC Documentation policy; interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A) The licensee has failed to ensure that an incident of alleged abuse of a resident by another resident, which resulted in harm or risk of harm to the resident was reported immediately to the Director. The incident was not reported until twelve days later.

Sources: CI#2991-000014-25; interview with management.

B) The licensee has failed to ensure that allegations of neglect were reported to the Director.

On a specified date, registered staff reported several allegations of resident neglect to management. A review of the Ministry of Long-Term Care Critical Incident System (CIS)- CIS Portal showed no evidence that a critical incident report was submitted to the Director with the allegations of neglect.

Sources: The home’s investigation notes; Ministry of Long-Term Care CIS Portal; Zero Tolerance of Resident Abuse and Neglect policy; interview with management.

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (2) (b)
Required programs
s. 53 (2) Each program must, in addition to meeting the requirements set out in section 34,
(b) provide for assessment and reassessment instruments. O. Reg. 246/22, s. 53 (2).

The licensee has failed to comply with the home's pain management program related to pain assessments being completed. In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to have written policies for the pain management program, and to ensure they are complied with. Specifically, registered staff did not comply with the licensee's requirement to complete a pain assessment for a resident when they complained of new pain.

Additionally, the resident had elevated pain levels on multiple occasions between two dates, and according to the home's policy would have also required a complete pain assessment. There was no pain assessment completed until a later date.

Sources: A resident's clinical records; home's policy title "Pain Management Policy"; interview with staff.

WRITTEN NOTIFICATION: Continence care and bowel

management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident had sufficient changes to remain clean, dry and comfortable.

A resident was involved in an incident and was found incontinent. The resident was required to receive personal care at specific times of the day. The resident's plan of care indicated that the resident had not received personal care at the required times. Management stated as a result of the investigation they determined staff did not provide personal care to the resident at the specified times.

Sources: A resident's plan of care; the home’s investigation notes; interview with management.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

The licensee has failed to ensure that when a resident was exhibiting responsive behaviours, action was taken to respond to the needs of the resident and that those actions were documented. During a specified time frame, a resident demonstrated responsive behaviours towards a co-resident. There were no assessments or plan of care updates documented related to addressing the responsive behaviours for the resident.

Sources: A resident's clinical records; the home's policy titled "Responsive Behaviour"; interview with staff.