

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:** January 21, 2026

**Inspection Number:** 2026-1490-0001

**Inspection Type:**  
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 dates: January 6-8, 12, 13, 16, 19-21, 2026

The following Critical Incident (CI) intakes were inspected:

- Intake: #00162335/ CI 2991-000027-25 related to medication management;
- Intake: #00164525/ CI 2991-000028-25 related to prevention of abuse and neglect;
- Intake: #00165248/ CI 2991-000031-25 related to resident care and support services regarding transferring and positioning techniques.

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Medication Management
- Responsive Behaviours
- Prevention of Abuse and Neglect

## INSPECTION RESULTS

### Non-Compliance Remedied

**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.

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NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: O. Reg. 246/22, s. 274 (b)**

Resident records

s. 274. Every licensee of a long-term care home shall ensure that,  
(b) the resident's written record is kept up to date at all times.

On an identified date in 2025, there was an incident during the transfer of a resident that resulted in an injury. Details of the incident were only noted in a risk management report, which is not part of the medical record for the resident.

On an identified date in 2026, a late entry progress note and assessment were updated in the resident's clinical progress notes.

**Sources:** clinical record for a resident; risk management report; interviews with staff.

Date Remedy Implemented: January 14, 2026

**WRITTEN NOTIFICATION: Duty to protect**

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

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Section 2 of Ontario Regulation 246/22 defines sexual abuse as follows “any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; (“mauvais traitements d'ordre sexuel”).

On an identified date, a resident was found in another residents room engaged in inappropriate sexual behaviours, until found by staff and separated. The resident who entered the room was assessed as being unable to consent based on their medical diagnosis and cognitive impairment.

**Sources:** Interviews with staff; Risk Management Report; clinical record for residents,

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including progress notes and assessments.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

### Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On an identified date, a resident was transferred in their room by two staff members. After the transfer it was noted that the resident had sustained an injury.

It was acknowledged that the resident was improperly transferred due to the resident sustaining an injury that was not there prior to the transfer.

**Sources:** Interview with staff; resident clinical record; risk management report; the home's internal investigation notes.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #004 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.

A resident was admitted to the home with no identified specific behaviours on admission paperwork. On several dates following their admission, the resident had exhibited the identified specific behaviours towards various staff members.

As per the home's policy, when a resident exhibits new responsive behaviours, staff are

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to complete assessments to identify potential triggers, contributing factors, and determine the pattern of behaviour using the Dementia Observational System (DOS) tool. Staff acknowledged that this not completed as expected on the identified dates.

**Sources:** resident clinical record including progress notes, assessments; interviews with staff; the home's policy titled "Responsive Behavior", dated April 1, 2021.

### **WRITTEN NOTIFICATION: Administration of Drugs**

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 140 (2)**

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The medication for an identified number of resident's were documented as provided, however it was determined not to have been administered as ordered on November 9, 2025.

**Sources:** Medication Incident Reports; interviews with staff; identified resident's clinical records.