

**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 20, 2025

**Inspection Number:** 2025-1701-0006

**Inspection Type:**

Complaint  
Critical Incident  
Follow up

**Licensee:** The Regional Municipality of Niagara

**Long Term Care Home and City:** Gilmore Lodge, Fort Erie

**INSPECTION SUMMARY**

The inspection occurred onsite on the following dates: October 7-10, 14, 16, 20, 2025

The following intakes were inspected:

- Intake #00157158 -Follow-up #: 1 – CO #001 Transferring and positioning techniques, O. Reg. 246/22, s. 40, 2025-1701-0005- CDD: October 6, 2025.
- Intake #00157413 – Critical Incident (CI) M635-000026-25 – Falls prevention and management
- Intake #00158017 - Complainant regarding prevention of abuse and neglect, medication management, and responsive behaviours.

**Previously Issued Compliance Order(s)**

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2025-1701-0005 related to O. Reg. 246/22, s. 40

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

- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

The licensee has failed to protect a resident from physical abuse by another resident.

Section 2 of Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On one occurrence, a resident with a documented history of responsive behaviours, entered another resident's room and physically harmed them. Staff intervened and escorted the resident with responsive behaviours out of the room. Following the

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incident, the resident who was physically harmed exhibited pain and had an identified injury requiring monitoring.

**Sources:** Resident clinical records, Critical Incident (CI) Report, interviews with management and registered staff.

## **COMPLIANCE ORDER CO #001 Responsive behaviours**

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

A) Educate and re-train all Personal Support Workers (PSWs) and Registered staff on two identified home areas on the home's Responsive Behaviours Policy, including but not limited to the staff's expectations of completing the Dementia Observation System (DOS) tool, the expected documentation, and analysis of observed behaviours in residents exhibiting responsive behaviours.

B) Document the education, including the components of education, the date the education was provided, and the name of the staff member(s) who provided the education and the name of the staff member(s) who were educated.

C) Conduct documentation audits of observed behaviours for any resident on the DOS tool charting in the two identified home areas over a two-week period to

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ensure completeness of record.

D) Maintain written records of the audits for inspector review, including the date and time of an audit completion, the name of the staff member(s) who completed the audits, and corrective actions (if any) that were taken after completion of these audits.

**Grounds**

The licensee has failed to ensure that behaviour monitoring for residents #001 and #002, who demonstrated responsive behaviours, was fully documented using the Dementia Observational System (DOS) assessment tool.

The home's policy required the staff to use tools like the Behavioural Supports Ontario (BSO) DOS and behavioural monitoring to track residents' mood and behaviours, identify triggers, and implement strategies to reduce responsive behaviours. A review of the DOS assessment tool's for resident #001 and resident #002 exhibiting responsive behaviors revealed incomplete documentation for both residents.

During an identified timeframe, resident #002 was placed on DOS monitoring due to incidents of physical aggression toward staff and co-residents, including more than one physical altercations. During an identified time, the DOS assessment tools were also incomplete for resident #001.

The Responsive Behaviours Therapeutic Advisor (RBTA) and the Associate Director of Resident Care (ADRC) acknowledged that staff did not document the observed behaviours of resident #002 on several occasions between the identified timeframe, and that the documentation for resident #001 was incomplete during an identified time as well. Due to incomplete documentation, behaviour analysis and

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planning were not completed for either resident as per their policy, which affected the planning and implementation of appropriate responsive behaviour interventions for these residents.

The home's failure to record and document the observed behaviours of resident #002 compromised the safety and security of resident #001 and others, potentially resulting in inadequate risk management and the inability to implement effective strategies to reduce responsive behaviours.

**Sources:** Clinical records of resident's, Home's Policy titled "Responsive Behaviours Program-Behavioural and Psychological Symptoms of Dementia", last revised on 03/17/25, interviews with the RBTA and ADRC.

**This order must be complied with by** December 19, 2025

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## REVIEW/APPEAL INFORMATION

**TAKE NOTICE** The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> floor  
Toronto, ON, M7A 1N3

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e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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**Health Services Appeal and Review Board**

Attention Registrar  
151 Bloor Street West, 9<sup>th</sup> Floor  
Toronto, ON, M5S 1S4

**Director**

c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8<sup>th</sup> Floor  
Toronto, ON, M7A 1N3  
e-mail: [MLTC.AppealsCoordinator@ontario.ca](mailto:MLTC.AppealsCoordinator@ontario.ca)

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).