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

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Public Report

Report Issue Date: April 10, 2025

Inspection Number: 2025-1490-0002

Inspection Type:
Proactive Compliance Inspection

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): April 1-4 and 7-10, 2025

The following intake(s) were inspected:

- Intake: #00143860 - Proactive Compliance Inspection (PCI) for R.H. Lawson Eventide Home.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

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.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas, specifically two storage room doors, were kept closed and locked when they were not being supervised by staff. The Executive Director (ED) and Director of Environmental Services (DES) were notified immediately and ensured they were kept closed and locked.

Sources: Observations and interview with ED and DES.

Date Remedy Implemented: April 1, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee has failed to ensure that drugs were stored in a medication cart that was used exclusively for drugs and drug related supplies. A medication cart was observed to have a designated drawer for wound care supplies. The Director of Care (DOC) acknowledged that wound care supplies should not be stored in the medication cart and the supplies were removed.

Sources: Observations; Medication Storage Areas Policy; interview with the DOC.

Date Remedy Implemented: April 8, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that the home's emergency storage of controlled substances in a double-locked dispenser was stationary in a medication room. The dispenser was secured on top of a cabinet that was portable. The licensee immediately secured the cabinet to ensure the dispenser remained stationary.

Sources: Observations; Medication Storage Areas Policy; interviews with a nurse and

DOC.

Date Remedy Implemented: April 9, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure controlled substances that were to be destroyed and disposed of were stored in a double-locked storage area within the home, separate from any controlled substances that were available for administration to a resident until the destruction and disposal occurred.

In accordance with Ontario Regulation (O. Reg.) 246/22, section (s.) 11 (1) (b), the licensee was required to ensure that the home's "Destruction and Disposal of Narcotic and Controlled Medications Policy" was fully implemented and complied with. An open ampule with residual narcotic was placed in a medication cup on a shelf in the medication room. The DOC acknowledged that the ampule should have been stored in a double locked storage area until it was destroyed and disposed of. The ampule was immediately destroyed and disposed as per procedures.

Sources: Observations; Destruction and Disposal of Narcotic and Controlled Medications Policy; interview with a nurse and the DOC.

Date Remedy Implemented: April 7, 2025

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. ii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,

The licensee has failed to ensure that the home's 2024-2025 Continuous Quality Improvement (CQI) initiative report included the dates actions were implemented and the outcomes of the actions for the home's priority areas of quality improvement which included reducing the number of potentially avoidable emergency department transfers, percentage of residents using antipsychotic medications without diagnosis and percentage of residents who fell in the last 30 days.

The report was updated with the required information.

Sources: 2024-2025 CQI Initiative Report; interview with the Quality Improvement Lead and ED.

Date Remedy Implemented: April 8, 2025

WRITTEN NOTIFICATION: Bathing

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice for a period of one week. Staff documented "not applicable" on one of the resident's scheduled bath days and there was no documentation to suggest the bath was completed or refused.

Sources: A resident's clinical record; interview with the DOC and other staff.

WRITTEN NOTIFICATION: Menu planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the menu evaluation included a written record of a summary of the changes made and the date the changes were implemented. The Registered Dietitian made suggestions on the home's menu evaluation and the Food Service Manager (FSM) acknowledged that changes were made, but there was no documentation of a summary of the changes and the date they were implemented.

Sources: Menu Evaluation and Approval Tool; interview with the FSM.

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that the home's cleaning and disinfection procedure of resident care equipment was implemented in accordance with evidence based practices. Specifically, a staff member did not clean and disinfect a shared piece of equipment after use.

Sources: Observations; Environmental Services for Infection Prevention and Control Policy; staff interview.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the CQI committee was composed of at least one employee of the licensee who was hired as a Personal Support Worker (PSW) or provides personal support services at the home and meets the qualification of PSW.

Sources: CQI committee Terms of Reference; CQI meeting minutes; interview with the Quality Improvement Lead.