Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2019	2019_755728_0025	019294-19, 019976-19, 020070-19	Critical Incident System

Licensee/Titulaire de permis

Eden House Care Facility Inc.
c/o 2663649 Ontario Inc. 295 Adelaide Street West, Suite 4007 TORONTO ON M5V 0L4

Long-Term Care Home/Foyer de soins de longue durée

Eden House Nursing Home
5016 Wellington County Road 29, R.R. #2 GUELPH ON N1H 6H8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARIA MCGILL (728)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 4-5, 2019.

The following intakes were completed in this critical incident inspection:
Log #019976-19 and Log #020070-19, related to a video of a resident posted to social media by a staff member of the home; and,
Log #019294-19, related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Coordinator, Registered Nurses (RN), Personal Support Workers (PSW), and Health Care Aides (HCA).

The inspector reviewed clinical records, plans of care, video footage, and relevant home documentation.

Observations were made of residents, staff to resident interactions, and resident care provision.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001 was afforded the right to privacy during care.

An anonymous complaint was submitted to the Ministry of Long-term Care (MLTC), related to a video of a resident completing an activity of daily living (ADL). The complaint identified that the staff member was PSW #102 but the resident and the long-term care home was unknown. On October 15, 2019, a Critical Incident (CI) was submitted to the MLTC related to a video that was posted on a social media platform of resident #001 completing an ADL. The video identified the username belonging to PSW #102. The resident's face was not visible in the video. The CI documented that DOC #104 identified the furniture in the room and was therefore able to identify resident #001.

The home's documentation related to the incident included a disciplinary letter that documented PSW #102 had violated the home's policy for privacy, confidentiality, and cell phone use by posting a video of a resident online.

Administrator #101 said that a number of their policies were violated in this instance.

The licensee failed to ensure that resident #001 was afforded the right to privacy when a video of them completing an ADL was posted to social media by PSW #102. [s. 3. (1) 8.]

Issued on this 6th day of November, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.