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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 22, 2024

Inspection Number: 2024-1268-0005

Inspection Type:
Complaint
Follow up

Licensee: Eden House Care Facility Inc.

Long Term Care Home and City: Eden House Nursing Home, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1-4, 2024

The following intake(s) were inspected:

- Intake: #00121767 - Follow-up #: 1 - O. Reg. 246/22 - s. 59
- Intake: #00126456 - Complaint regarding resident care and falls prevention and management

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1268-0004 related to O. Reg. 246/22, s. 59

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

Infection Prevention and Control

Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
A resident fell, which resulted in injury. Staff acknowledged that they forgot to complete part of the resident's care prior to the fall.

At the time of the incident and when completing the inspection, the resident's plan of care did not set out clear directions to staff.

Failure to provide staff with clear directions caused the resident an injury.

Sources: interviews with staff and record review of a resident's clinical records.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the implementation of the resident's plan of care.

Rationale and Summary
A resident sustained an injury. Staff communicated with the resident's SDM regarding the care that was being provided to the resident. After further assessment of the resident, staff changed the care that was being provided to the resident, but did not communicate that change to the resident's SDM.

Staff said the change in care should have been communicated to the resident's SDM.

By failing to communicate this change to the resident's SDM, the SDM did not have the opportunity to fully participate in the implementation of the resident's plan of care.

Sources: interview with staff and record review of a resident's clinical records.

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