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
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Waterloo, ON, N2V 1K8
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Public Report

Report Issue Date: May 1, 2025

Inspection Number: 2025-1268-0004

Inspection Type:
Critical Incident

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): April 23-25, 28-30, and May 1, 2025.

The following intake(s) were inspected:

- Intake: #00143952 related to prevention of abuse and neglect
- Intake: #00144567 related to falls prevention and management

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

Prevention of Abuse and Neglect
Falls Prevention and Management

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: FLTCA, 2021, s. 6 (1) (a)
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,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care related to the use of a liner as one of their continence care products.

A few days later, the plan of care was updated to ensure that the resident's continence care products were specified in the plan of care.

Sources: Critical Incident (CI) report, the resident care plan, interview with the Director of Care (DOC).

Date Remedy Implemented: April 29, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident related to their falls interventions, was provided as specified in the plan. As per the resident's plan of care, staff were to check and ensure that their room

environment was free of clutter and tripping hazards, every shift. During two observations, the resident's room environment was found with varying personal items and there were some tripping hazards identified.

On the following day, the home took actions to ensure that the resident's room environment was reduced of clutter and free of tripping hazards.

Sources: Room observations, the resident's care plan, interviews with the DOC and other staff.

Date Remedy Implemented: May 1, 2025

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 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 ensure that a resident was protected from neglect by multiple staff staff members.

For the purpose of the Act and Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was not provided staff assistance with their personal and continence care needs for three days. During the period that they were not assisted with continence care, the resident experienced mild symptoms during their bowel episodes, which

placed them at potential risk of harm for experiencing infections and other health concerns.

Sources: CI report, Long-Term Care Home (LTCH) Investigation notes, the resident's clinical records, interview with a Personal Support Worker (PSW) and other staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when they had reasonable grounds to suspect that neglect had occurred to a resident that placed them at risk of harm, that this information was immediately reported upon which it was based to the Director. It was not until the next day that the Director was notified of the alleged incident of neglect.

Sources: CI report, After Hours notification report, interview with the DOC.