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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: March 19, 2025
Inspection Number: 2025-1446-0001
Inspection Type: Critical Incident
Licensee: Haldimand War Memorial Hospital
Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 17-19, 2025.

The following intake was inspected:

- Intake: #00132453/Critical Incident (CI) #2963-000013-24 related to Infection Prevention and Control.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is

immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately inform the Director or call the Ministry's after-hours line when Public Health declared a respiratory outbreak in the home on November 18, 2024.

Sources: Critical Incident (CI) #2963-000013-24, interview with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that a recommendation issued by the Chief Medical Officer of Health was followed when during a confirmed respiratory outbreak, weekly Infection Prevention and Control (IPAC) audits were not conducted for two weeks.

Sources: Interview with staff.

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