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: June 17, 2025
Inspection Number: 2025-1446-0003
Inspection Type: Critical Incident
Licensee: Edgewater Gardens Long-Term Care Centre
Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville

INSPECTION SUMMARY

The inspection occurred on-site on the following dates: June 3-5, 9-12, 16, 2025

The following intake was inspected:

- Intake #00146828/ Critical Incident (CI) 2963-000007-25 was related to falls prevention and management.

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

Continence Care
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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 a resident's written plan of care related to use of their mobility device set out clear directions to staff.

Sources: Resident clinical records, interviews with nursing staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 failed to ensure care was provided to a resident as set out in their plan of care related to positioning.

Sources: Resident observation, clinical records, interviews with direct care staff and nursing management.

WRITTEN NOTIFICATION: Bed rails

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails

are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

When a resident had bed rails in use, the licensee failed to assess the resident in accordance with their bed rail safety and entrapment policy on multiple occasions.

Sources: Resident clinical records, bed rail safety and entrapment policy, interviews with nursing management and the Administrator.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home failed to ensure the pain management program was followed for a resident.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a pain management program to identify and manage pain in residents, and that it was complied with. Specifically, staff did not comply with the pain management policy, which required staff to complete a pain assessment when the resident expressed new pain.

Sources: Resident clinical records, pain management policy, interviews with nursing

staff, nursing management and the Administrator.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (1) 1.
Requirements relating to restraining by a physical device
s. 119 (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act or pursuant to the common law duty described in section 39 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.

The licensee failed to ensure that when restraining a resident, staff applied the physical device in accordance with manufacturer's instructions.

Sources: Resident observation, clinical records, manufacturer's instructions for restraint, interview with nursing staff.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 1.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a

physician or registered nurse in the extended class.

The licensee failed to ensure that when a resident was restrained by a physical device, the device had been ordered or approved by a physician or registered nurse in the extended class for this use.

Sources: Resident clinical records, Restraint & Personal Assistance Services Device Resident List, interviews with nursing management.

COMPLIANCE ORDER CO #001 General requirements

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Evaluate and update the home's falls prevention and management program, specifically, the definition of a fall in the home's falls prevention policy, in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices. Maintain a written record of the updates made and evidence-based or prevailing practices referenced, for the Ministry of Long-Term Care (MLTC) Inspector's review.
2. Train all direct care staff on the revised falls prevention and management program, including the definition of a fall and designation-specific responsibilities

for responding to a resident who has fallen. Maintain a written record of what education was provided, to whom, on what date, by whom, and the signatures of staff in attendance, for the MLTC Inspector's review.

Grounds

The licensee failed to ensure that the falls prevention and management program was evaluated and updated in accordance with evidence-based practices and, if there were none, prevailing practices.

Rationale and Summary
The home's fall prevention policy defined a fall as "any unintentional change in position where the resident ends up on the floor, ground or other lower level", including witnessed and unwitnessed falls, with or without injury, and excluding near falls/ misses. An unwitnessed fall was described as "resident found on floor, where neither the resident nor anyone else knew how they got there". A near fall/ miss incident included "successful interventions (i.e., resident's bed has been lowered to the floor with tumble mats in place, because staff anticipate that resident may slide or crawl out of bed)".

Following a resident's fall, the home's fall prevention policy directed staff to carry out specified actions, including assessments, referrals and communication. When a resident experienced a near fall/ miss (for example, "when a resident slides out of bed onto a tumble mat"), staff were expected to document the incident, ensure safety measures in place, change the care plan and place incident on the 24-hour shift report.

The Resident Assessment Instrument Minimum Data Set 2.0 User's Manual, referenced in the home's fall policy, and the Registered Nurses' Association of Ontario defined a fall as an event that results in a person coming to rest inadvertently on the ground, floor or lower level with or without injury.

The home's Administrator elaborated that when a resident was found on their floor mat, having lowered them self from a bed in the lowest position, this would not be considered a fall in accordance with the home's policy. They acknowledged that this criteria was not derived from an evidence-based practice guideline.

On a specified date, a resident was involved in an incident that was not considered a fall based on the definition of a fall in the home's policy. As a result, staff did not conduct specified nursing assessments post-incident.

When the home's policy, specifically the definition of a fall, was not in alignment with evidence-based practices, residents were at risk of of receiving inconsistent follow-up by staff for incidents which met the definition of a fall according to best-practices, but not the home's policy. Further, there were resident safety concerns posed when staff did not consider unwitnessed near fall/ miss incidents to be an unwitnessed fall.

Sources: Resident clinical records, critical incident report 2963-000007-25, falls prevention policy, evidence-based best practice guidelines, interviews with nursing staff, nursing management and the Administrator.

This order must be complied with by August 29, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.