Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Jun 21, 2021	2021_750539_0006	003755-21	Critical Incident System

Licensee/Titulaire de permis

Eden House Care Facility Inc.
c/o 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

VALERIE GOLDRUP (539)

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): June 7, 9, 10, 2021.

The following intake was completed in this Critical Incident System (CIS) inspection:

Log #003755-21, related to improper treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Care Coordinator, the Housekeeping Supervisor, Maintenance, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Behavioural Support Ontario (BSO) RPN and Health Care Aide, (HCA), Housekeeping and Dietary staff.

During the course of the inspection, the inspector observed resident and staff interactions, and infection prevention and control practices. They reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in writing, at a minimum, in specified home areas, during specified time periods, and that a record of the measurements were kept.

As of May 15, 2021, Ontario Regulation 79/10 included additional amendments related to cooling requirements and air temperatures in the Long-Term Care (LTC) home.

The home was required to at a minimum measure and document in writing the air temperatures in the following areas of the home: two resident bedrooms in different parts of the home, and one resident common area on every floor of the home.These temperatures were required to be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Maintenance staff stated they did not document the air temperature of the home. They regulated the air temperature based on the temperatures read on the thermostats.

Registered staff stated they did not measure and document air temperatures in the home during the evening or night shifts in any home areas.

The home did not enact the additional amendments required by the LTC licensee related to air temperature monitoring including keeping a written record of the home's air temperatures of specified areas.

Sources: record of the home's documented air temperatures, interviews with Maintenance and Registered Staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure temperatures are measured and documented in writing, at a minimum in the following areas of the home: 1. At least two resident bedrooms in different parts of the home. 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor;at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, and a record of the measurements were kept, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that a prohibited device was not used to restrain a resident.

A resident was identified to be at high risk of falls. On a specified night a prohibited device was used as an intervention to reduce their falls from bed. The device was not ordered for the resident.

Staff at the home stated the prohibited device would be considered a restraining device and should not be used by the home.

The resident was restrained with a prohibited device that limited their movement and the use of the device caused a risk of harm to the resident.

Sources: CIS Report, observation of the resident, the resident's progress notes and assessments, interviews with Personal Support Workers and Registered Staff.

Issued on this 14th day of July, 2021

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

Original report signed by the inspector.