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

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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
Oct 13, 2021	2021_872218_0019	014679-21	Complaint

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

APRIL RACPAN (218)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 17, 20-23, 27-29, 2021.

The following intake was completed in this inspection:

-Log #014679-21 related to staffing and bathing concerns.

Critical Incident Inspection #2021_872218_0018 was completed concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC)/Infection Prevention and Control (IPAC) Lead, the Behavioural Supports of Ontario (BSO) Lead, Registered staff, a Public Health Inspector, Police authorities, Personal Support Workers (PSWs), and students.

During the course of the inspection, the inspector(s) conducted a tour of the resident home areas (RHAs), observed IPAC practices, resident care provision, resident/staff interactions, and completed resident and staff interviews. The inspector also reviewed clinical health records, posting of required information, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
1 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. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week.

On three separate days in September 2021, several residents did not receive their scheduled baths as required, because the home was short staffed. The baths were not rescheduled resulting in the residents receiving only one bath that week.

The Administrator shared that they identified a concern related to the home's process with rescheduling missed baths and they are in the process of developing a new protocol to address the concern.

Failing to ensure that each resident of the home was bathed twice a week placed residents at risk for poor personal hygiene and other care concerns.

Sources: LTCH's bathing schedules, interviews with residents, interview with the Administrator and others. [s. 33. (1)]

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 that each resident of the home is bathed, at a minimum, twice a week, to be implemented voluntarily.

Issued on this 20th day of October, 2021

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

Original report signed by the inspector.