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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 8, 2023
Original Report Issue Date: May 17, 2023
Inspection Number: 2023-1268-0004 (A1)
Inspection Type: Complaint Follow up Critical Incident System
Licensee: Eden House Care Facility Inc.
Long Term Care Home and City: Eden House Nursing Home,Guelph

Amended By	**Inspector who Amended Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2023.06.21 15:21:50 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to: reflect an extension of the compliance due date for Compliance Order (CO) #001, #002, and #003 to August 9, 2023. The inspection #2023-1268-0004 was completed on March 29-31, 2023 and April 3-6, 11-14, 17-21, 2023.

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Lead Inspector JanetM Evans (659)	**Additional Inspector(s)** Dianne Tone (000686) Nuzhat Uddin (532)
Amended By JanetM Evans (659)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 29-31, 2023 and April 3 - 6, 11 - 14, 17 - 21, 2023

The following intake(s) were inspected:
· Intake: #00002725 - related to alleged abuse of residents.

- Intake: #00017973 - related to staff to resident neglect.
- Intake: #00018884 - resident to resident altercation
- Intake: #00019635 - related to fracture of unknown cause.
- Intake: #00020373 - related to resident to resident altercation.
- Intake: #00020676 - Follow-up #: 1 related to bathing
- Intake: #00021339 - Complaint related to wound care, plan of care, unknown cause of fracture and death of resident.
- Intake: #00021502 - Complaint related to alleged neglect
- Intake: #00022484 - Complaint related to continence care and bowel management
- Intake: #00012383 - related to a fall and death of a resident; and
- Intake: #00004690 - related to an injury which resulted in a significant change for a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1268-0002 related to O. Reg. 246/22, s. 37 (1) inspected by JanetM Evans (659)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1).

The licensee failed to protect a resident from abuse by a co-resident.

O. Reg. 246/22 s. 2 (1) defines "physical abuse", subject to subsection (2), as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
Two residents were known to have responsive behaviours towards each other.

In January 2023, an altercation between the residents was witnessed by staff, which resulted in one resident falling and sustaining an injury.

A similar incident had occurred between these two residents in December 2022.

Failure to protect the one resident from an altercation with their co-resident resulted in their fall and injury.

Sources: CIS, progress notes, plan of care. Risk management, pain assessment, interview with DOC and staff.
[659]

WRITTEN NOTIFICATION: Orientation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 8.

The licensee failed to ensure that orientation training related to emergency and evacuation procedures was completed for all staff. Specifically, they failed to ensure all staff were trained in the home's procedures related to a code white prior to working.

Rationale and Summary:

A document which listed active staff hired and date of their hire as of January 2023, was provided. The document did not list any specific trainings provided to the staff. The administrator stated that all staff listed on the document had received the required training as part of their orientation.

Two RPNs hired within the last year, said they had not received any training from the home in relation to code white procedures.

Failure to provide staff with training on emergency procedures including code white put the residents and staff at risk of not knowing what to do during high-risk situations.

Sources: training document, interviews with Administrator and staff
[659]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to implement strategies to reduce or mitigate falls for a resident.

Rationale and Summary:
A resident was assessed as at risk for falls. Their plan of care directed staff to ensure the bed was kept in the lowest position.

A PSW heard an alarm going off and found the resident on the floor. Two PSW said the resident's bed had been left in a raised position. The resident was initially assessed by an RPN to have no injury. An RN later assessed the resident to have pain and swelling in their neck and pain in their shoulder.

The home's investigation showed a PSW had left the resident's bed in a raised position following care.

Failing to implement fall prevention strategies to lower the bed for the resident as outlined in their plan of care, resulted in the resident falling and sustaining an injury.

Sources: Home's investigation, Progress notes, plan of care, interviews with DOC and staff
[659]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee failed to ensure that when a resident exhibited a pressure ulcer, the resident received immediate treatment and interventions to promote healing.

Rationale and Summary:
A PSW notified a RPN that the resident had an area of altered skin integrity.

The RPN assessed the resident's wound. They notified the RN; however, neither the RPN or RN provided immediate interventions, and the wound worsened.

The DOC reported that the resident experienced negative outcomes, including discomfort and a deteriorating wound, when the wound went untreated for 72 hours and the resident did not receive immediate treatment and interventions to promote healing.

The resident's health and quality of life were moderately impacted when there was a delay in implementing treatment and interventions to promote healing.

Sources: Record review i.e., progress notes, plan of care, wound assessment, investigation notes, CIS #2777-000001-23, interview with the DOC and other staff.
[532]

WRITTEN NOTIFICATION: Continence care and Bowel Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee failed to ensure that a resident's plan of care for continence management was individualized to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Rationale and Summary:
A continence assessment for a resident documented the resident as incontinent.

Four months later, the home received a concern that the resident had not been receiving timely assistance for continence.

The DOC stated that they met with the resident and a toileting schedule was agreed on.

The resident's plan of care directed staff to follow the scheduled times for toileting. It did not include direction as to when those scheduled times were.

Two PSWs said the resident would call for toileting assistance. One PSW thought there was a toileting schedule but did not know details about the times for toileting the resident.

A RN said there was no documentation related to the scheduled toileting for the resident in either POC or the eTAR.

The Administrator acknowledged there was no individualized toileting schedule in the resident's plan of care to promote and manage bowel and bladder continence.

Failure to document and implement the scheduled toileting plan for the resident risks the resident not receiving timely assistance with toileting.

Sources: Home's investigation notes, plan of care, interviews with DOC, Administrator, and staff [659]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)

The licensee failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Rationale and Summary:
In January 2023, the DOC received a concern that a resident had not received timely assistance for toileting.

The home's investigation documented that staff were aware the resident required assistance with toileting but did not return to assist the resident after completion of the task they had been involved in. A PSW stated they had told the resident they would return after giving out trays but they forgot to return and provide assistance. The resident had a visitor present, and they assisted the resident to change as the resident had been incontinent.

Failure to provide the resident with assistance to toilet may risk the resident's comfort, dignity and safety if the resident were to attempt to self-toilet.

Sources: Home's investigation, plan of care, CCRS, interviews with DOC and staff.
[659]

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must comply with O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee shall ensure:

1. That a skin and wound lead is appointed for the home.
2. That a review of the Home's skin and wound program is undertaken and the program updated as required to provide for a clinically appropriate assessment instrument for staff to use for skin and wound assessments, which includes directions to staff related to when and how to use this form.
3. Direct care staff and registered staff will be trained on their role as it relates to resident skin and wound care. The training should be documented and include the date the training was completed, the name of staff completing the training, the content of the

training, as well as the name of the person providing the training. The documentation of the training should be maintained at the home.

4. The skin and wound lead shall conduct a weekly audit of skin and wound assessments to ensure that all residents who exhibit areas of altered skin integrity have an initial and/or weekly skin and wound assessment completed.

5. The audit should be documented and include the date of the audit, the name of the resident, the area of altered skin integrity, any corrective action taken if an assessment had not been completed, as well as the name of the person conducting the audit. The audits should continue for a minimum of one month or until the home believes they are in compliance. The audits should be maintained at the home.

Grounds

The licensee failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, or pressure ulcers, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:

A) In January 2023, a PSW notified a RPN that the resident had an area of altered skin integrity.

The RPN assessed the resident's area of altered skin as a pressure ulcer with blistering. They notified the RN. Neither the RPN or RN assessed the wound or documented on the wound area and as a result no treatment was initiated and the wound worsened.

The DOC reported that because of this, the resident experienced discomfort and a deteriorating wound.

Sources: Record review i.e., progress notes, plan of care, wound assessment, investigation notes, CIS #2777-000001-23, interview with the DOC and other staff
[532]

B) In January 2023, a PSW reported a bruise on a resident's leg to a RN.

The RN forgot to assess and document an initial skin and wound assessment until the following day when the PSW reported the same bruise to the registered nurse.

The resident complained of pain upon movement and an analgesic was administered for pain. They were transferred to hospital with a significant injury.

Failure to complete an initial skin and wound assessment of the resident's leg significantly impacted the resident's health and quality of life when there was a delay in assessment and subsequent treatment.

Sources: Record review i.e., progress notes, plan of care, wound assessment, investigation notes, interview with the DOC and other staff.

[532]

This order must be complied with by

July 9, 2023

COMPLIANCE ORDER CO #002 Behaviours and Altercations

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 60 (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall comply with O. Reg. 246/22 s. 60 (a)

The licensee shall ensure that:

1. All staff will be trained on the licensee's responsive behaviour program, specifically addressing the implementation of procedures/processes to minimize harm and risk of harm to residents and staff related to responsive behaviours. The training should be documented and include the date the training was completed, the name of staff completing the training, the content of the training, as well as the name of the person providing the training. The documentation of the training should be maintained at the home.

2. A review of the identified resident's responsive behaviours will be completed by the licensee with input from external resources to assist in making revisions to the resident's plan of care.

3. An interdisciplinary meeting will be completed with the BSO and DOC on a regular basis, not less than monthly, to review resident #005's responsive behaviours and effectiveness of interventions. Minutes of the meetings should be maintained. Any changes are to be reflected in the resident's plan of care. The meetings should continue until such a time as the identified resident's behaviours are stabilized or being effectively managed

Grounds

The licensee failed to ensure that procedures were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of an identified resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary:

The home's behaviour management program directed staff to notify the DOC, the attending physician and BSO of a resident's behaviours. An algorithm in the program identified the resident as high risk because the resident's behaviours were not manageable in the home and interventions were not effective. The algorithm documented that in situations where a resident is deemed high risk, emergency responders should to be contacted and a Form 1 completed when there is an episode of responsive behaviours.

The home's Code White policy provided guidelines for implementation in situations where any individual was behaving in a potentially dangerous manner towards themselves or others and indicated a potential for escalating beyond the ability of the staff present to manage the situation.

A resident had a history of responsive behaviours which included both physical and verbal aggression towards co-residents and staff.

In January 2021, an assessment documented the resident as a very high risk for violence.

A specialized Geriatric assessment completed in December 2021, documented concerns about the resident's refusal of care and verbal and physical threatening behaviours.

In June 2022, the resident was assessed at hospital for increased behaviours and returned to the home with recommendations for medication management.

A Continuing Care Reporting System (CCRS) assessment completed in October 2022, documented the resident's aggressive behaviour score (ABS) of zero out of twelve. Three months later their ABS was documented as five out of twelve.

Between January 1 – April 19, 2023, there were more than 12 documented incidents of aggressive responsive behaviours involving the resident.

One to one (1:1) supervision had been initiated for the resident in February 2023, to assist with behaviour monitoring and management. On two occasions during the inspection, the 1:1 was noted to not have the resident in their sightlines. In one instance the 1:1 was observed in another resident's room chatting to a resident and in another instance they were seen wheeling a resident down a different hallway. The BSO manager stated that the 1:1 was to have the resident within their sight at all times.

The DOC said the resident's behaviours were high risk at the time of the inspection and they were not certain why the resident had not been sent out for assessment.

In April 2023, the resident's behaviours had escalated. There were numerous incidents documented that the resident was being aggressive towards staff and co-residents and chasing staff. No Code White was called for any of these incidents.

BSO staff, the DOC and an RN said there was risk of harm to others from the resident's behaviours. Staff verbalized fear of the resident, as had a co-resident.

Failure to implement procedures to minimize potential harmful altercations between residents or towards staff or to include procedures to assist residents and staff who were at risk of harm or who were harmed as a result of the resident's responsive behaviours, posed ongoing risk of harm to both residents and staff.

Sources: observations, progress notes, care plan, eMARs Jan – April, SGS consult December 9, 2021, Assured Care Consulting Violence assessment, Jan 28, 2021, CCRS Outcome scores October 2022 and January 2023, Responsive Behaviour Program, revised 6/19, DOS, Risk management, Code white, interviews with DOC, BSO manager, physician and staff.

[659]

This order must be complied with by

July 9, 2023

COMPLIANCE ORDER CO #003 Additional training - Direct care staff

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall comply with O. Reg. 246/22, s. 261 (1) 2.

The licensee shall ensure:

1. All direct care staff, including PSWs and registered staff receive training on the home's skin and wound program. The training for PSWs includes at a minimum the identification, reporting and documentation of altered skin integrity. The training for registered staff includes at a minimum, the use of a clinically appropriate assessment tool for skin and wound and timelines for completion of skin and wound assessments and procedures to follow if they are unable to complete the scheduled skin and wound assessment.
2. The training identified in #1 is documented and a record is kept in the home. The documentation should include the date the training was provided, the name of the staff completing the training, the content of the training and name of the person providing the training.

Grounds

The licensee has failed to ensure that training was provided to all direct care staff for the skin and wound program.

Pursuant to paragraph 6 of subsection 82 (7) of the FLTCA, the licensee is required to ensure that all staff who provide direct care to residents receive training in any other areas provided for in the regulations.

As per O. Reg 246/22 s. 261 (1), the licensee is required to ensure that all direct care staff received training in skin and wound care.

Rationale and Summary:

None of the home's direct care staff, including Personal Support Workers (PSW) and the registered staff received training in skin and wound care.

Two PSW, a RPN and a RN all stated that they did not receive training on the home's skin and wound program.

The DOC said that skin and wound training had not been provided. There was a change over in management company and the staff were waiting to receive their training. The DOC also indicated that the home currently did not have a nurse with specific training in skin and wound care nor did they have access to an enterostomal therapy (ET) nurse.

There was potential risk when training and education of the required programs was not provided to all direct care staff. This increased the likelihood that appropriate care would not be in place when addressing care concerns related to skin and wound management.

Sources: skin and wound education and training records, interviews with the DOC and staff.

[532] [000686]

This order must be complied with by

July 9, 2023

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.