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

Original Public Report

Report Issue Date: September 11, 2023	
Inspection Number: 2023-1268-0005	
Inspection Type: Complaint Follow Up (F/U)	
Licensee: Eden House Care Facility Inc.	
Long Term Care Home and City: Eden House Nursing Home, Guelph	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.09.13 09:24:57 -04'00'
Additional Inspector(s) Daniela Lupu (#758)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 9-11, 14-17, 2023

The following complaint intake(s) were inspected:

- Intake: #00086614 - related to skin and wound care
- Intake: #00087942 - related to various care concerns

The following follow-up (F/U) intake(s) were inspected:

- Intake: #00088565 – F/U to Compliance Order (CO) #001 related to s. 55 (2)(b)(i) skin and wound care from inspection #2023_2023_1268_0004 with a compliance due date of August 9, 2023
- Intake: #00088566 – F/U to CO #002 related to s. 60 (a) behaviours and altercations from inspection #2023_2023_1268_0004 with a compliance due date of July 9, 2023
- Intake: #00088567 – F/U to CO #003 related to s. 261 (1) 2 - additional training – direct care staff, from inspection #2023_2023_1268_0004 with a compliance due date of August 9, 2023

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

CO #001 from Inspection #2023-1268-0004 related to O. Reg. 246/22, s. 55 (2) (b) (i) inspected by Daniela Lupu (#758)

CO #002 from Inspection #2023-1268-0004 related to O. Reg. 246/22, s. 60 (a) inspected by Katherine Adamski (#753)

CO #003 from Inspection #2023-1268-0004 related to O. Reg. 246/22, s. 261 (1) 2. inspected by Daniela Lupu (#758)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements for Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that actions taken with respect to a resident's skin concerns and the resident's responses to these interventions were documented.

Rationale and Summary

i) A skin concern was observed on the resident. The skin concern was to be assessed and treatment with special instructions was implemented, as needed. If treatment was applied to the skin concern, it was to be documented in the resident's electronic Treatment Administration Record.

Over several weeks, and on several occasions, there was missing documentation of the assessments and/or treatments.

ii) A resident was prescribed a specific skin care treatment which was to be documented when applied.

Over several weeks, there was incomplete documentation of the administration of the treatment.

iii) A resident expressed pain during the assessment of one of their skin concerns.

There was no documentation of the actions taken to address the resident's pain and the resident's response.

iv) A resident's skin concern was to be monitored daily and staff were to document skin observations every shift in the Point of Care (POC) under the skin observation task.

Over several weeks, there was incomplete documentation in the POC related to daily monitoring of the skin concerns. Additionally, there was no documentation of the skin observations on the paper records.

The Director of Care (DOC) said all the care and/or interventions provided to a resident should be documented.

By not documenting observations and interventions taken with respect to a resident's skin care, pain and the resident's responses to these interventions, staff members may not have been aware of the changes in the resident's skin condition, and it may have delayed the implementation of appropriate actions. Additionally, gaps in the documentation of skin care would make difficult to evaluate the interventions in place.

Sources: a resident's clinical documentation, interviews with the DOC, and other staff. [#758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident's skin concerns were assessed 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 resident was at risk of skin concerns. Several new skin concerns were observed, some of which deteriorated and required prescription treatment ordered by the physician.

There were no skin assessments completed for the skin concerns.

By not assessing the residents multiple skin concerns, registered nursing staff may not be aware of changes to these skin concerns, and appropriate interventions may not be initiated in a timely manner if

these areas began to deteriorate.

Sources: a resident's clinical records, interviews with an RN, the DOC and other staff. [#758]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 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 a resident received immediate interventions to promote healing and prevent infection of their skin concern.

Rationale and Summary

A resident's previously resolved skin concern reoccurred and deteriorated; treatment was prescribed by the physician. A subsequent assessment showed that the skin concern was deteriorating further. The physician was not notified of the deteriorating skin concern; therefore, no new treatment interventions were implemented, and the skin concern deteriorated further.

The DOC stated that when the treatment was not effective and the resident's skin concern began to deteriorate, the physician should have been informed to re-assess the resident and re-evaluate the treatment options.

By not providing immediate interventions to promote healing and prevent infection when changes in a resident's skin concern were observed, this resulted in a deterioration of the resident's skin concern.

Sources: a resident's clinical records, interviews with the DOC and other staff. [#758]

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) (iv)

The licensee failed to ensure that a resident's skin concern was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident had an area of skin concern. Weekly skin and wound assessments for a two-month period were not completed or included incomplete documentation and the resident's skin concern deteriorated during this time.

The DOC said skin assessments should be completed weekly, and should include all the information listed in the assessments as per the home's skin and wound protocol.

Gaps in the completion of the weekly skin assessments of a resident's skin concern increased the risk that appropriate interventions were not implemented in a timely manner when the area started to deteriorate.

Sources: a resident's clinical records, interviews with the DOC and other staff. [#758]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that strategies developed to respond to a resident's responsive behaviours, were implemented, as required.

Rationale and Summary

A resident was prescribed medications with specific administration times included in their care plan for the management of triggers related to responsive behaviours. The resident's medications were not administered as per the times directed in their care plan.

Registered staff acknowledged that the resident exhibited responsive behaviours around the specific time that they were to receive their medication.

When staff did not provide a resident medication for managing a known trigger as specified in their care plan, the residents' responsive behaviours were potentially related to inadequate management of that trigger.

Sources: a resident's clinical records, interviews with the complainant and staff. [#753]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee failed to ensure that a response, that included an explanation of what was done to solve the complaint was provided to the person who made the complaint for care concerns related to a resident.

Rationale and Summary

The home received several complaints concerning the care of a resident.

The DOC acknowledged receiving several concerns related to a resident and not providing a response back to the complainant including an explanation of what was done to solve the complaint.

By not providing a response to the complainant regarding what actions were taken by the home to resolve their concerns, the complainant was provided potentially inaccurate information from other sources.

Sources: the home's Complaints Binder, interviews with the complainant and the DOC. [#753]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee failed to ensure that a documented record was kept in the home for every verbal complaint made to the licensee or a staff member concerning the care of a resident.

Rationale and Summary

Staff acknowledged receiving, but not documenting several complaints from a complainant related to a resident's care. The DOC also acknowledged receiving verbal concerns from the complainant related to a resident care.

There were no documented complaints, investigations or responses to the complainant related to their concerns contained in the home's Complaints Binder.

When the complainant's concerns were not documented, there was no record of the concerns, investigation or follow-up actions taken by the home, and concerns remained unresolved.

Sources: the home's Complaints Binder, interviews with complainant, DOC and other staff. [#753]

WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 6.

The licensee failed to ensure that the use of a physical device to restrain a resident under section 35 of the Act was documented and without limiting the generality of this requirement, the licensee failed to ensure that all assessments, reassessments, and monitoring, including the resident's response were documented.

Rationale and Summary

A resident was prescribed a physical restraining device that was applied.

There was no assessment, reassessment or monitoring including the resident's response documented related to the restraint, and this was acknowledged by the DOC.

Additionally, the resident's care plan and kardex did not include documentation for the requirement of a physical restraint, or directions for staff for the use of the restraint.

When a resident was not assessed for the use of a restraint and there were no directions documented for staff to follow for applying the restraint, the resident was at risk of an injury.

Sources: observations, a resident's physical and electronic charting, interviews with the DOC and other staff. [#753]

WRITTEN NOTIFICATION: Administration of Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was prescribed several medications. The directions for use specified that the medications be administered to the resident in a specific way. Staff did not administer the resident's medications accordance with the instructions specified.

When a resident's medications were not administered as specified, there was a risk that the resident was not receiving their full dose of medication.

Sources: observations, a resident's physical and electronic charting, interviews with a complainant, DOC and other staff. [#753]