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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 12, 2024

Inspection Number: 2024-1268-0001

Inspection Type:
Critical Incident

Licensee: Eden House Care Facility Inc.

Long Term Care Home and City: Eden House Nursing Home, Guelph

Lead Inspector	**Inspector Digital Signature**
Craig Michie (000690)	Craig R Michie Digitally signed by Craig R Michie Date: 2024.02.12 15:24:29 -05'00'

Additional Inspector(s)
Kristen Owen (741123) was present at this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-19, 31, 2024 and February 1, 6, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
• Intake: #00100146, and Intake: #00101611, related to fall prevention and management.
• Intake: #00105064, related to infection prevention and control.
• Intake: #00106118, related to prevention of abuse and neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when staff had reasonable grounds to suspect that when abuse of a resident by staff occurred, that they immediately reported the suspicion and the information upon which it is based on to the Director. Pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary
A staff member reported allegations of abuse towards several residents via email to the Director of Care (DOC).

The DOC was not aware of the concerns until 14 days later.

A critical incident (CI) report was submitted to the Director 16 days after the alleged abuse occurred.

DOC acknowledged that the incident should have been reported to Registered staff on the day that it occurred.

Failure to immediately report concerns delayed the home's response, and may have delayed the Director in responding to the incident.

Sources: CI report, interview with DOC and other staff.
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WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, a Head Injury Routine (HIR) assessment was conducted.

Rationale and Summary
The resident had a fall and an HIR was initiated. The HIR was completed for only 24 hours after the fall.

Staff did not comply with the home's policy, Falls – Resident, 05-02-01 Policy and Head Injury Routine, 05-04-02 Policy, that stated that the resident's condition should be assessed every shift for 72 hours per schedule outlined in the policy. Therefore, the HIR assessment was not fully completed.

The Director of Care (DOC) said that the HIR assessments were only completed for 24 hours after the fall and not the 72 hours as required.

By not completing HIR assessments as required, there was a potential risk of a head injury not being detected.

Sources: Falls - Resident, 05-02-01 Policy, Head Injury Routine, 05-04-02 Policy, the resident's

clinical records, Interview with DOC and other staff members.
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