

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

Public Report

Report Issue Date: March 14, 2025

Inspection Number: 2025-1268-0003

Inspection Type:

Critical Incident
Follow up

Licensee: Eden House Care Facility Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11-14, 2025.

The following intake(s) were inspected:

- Intake: #00137806 - Compliance order follow up.
- Intake: #00138166 - Alleged neglect of a resident.
- Intake: #00138168 - Alleged neglect of a resident.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1268-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

- Contenance Care
- Infection Prevention and Control

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INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to comply with their continence program, when a resident's care was documented inaccurately by staff.

Sources: Critical incident report, home's investigation notes, and interview with Director of Care.

WRITTEN NOTIFICATION: Continence care and bowel management

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

Non-compliance with: O. Reg. 246/22, s. 56 (2) (d)

Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

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The licensee has failed to ensure that a resident received assistance and support from staff regarding their care. A resident was not assisted with toileting on two different occasions. Delayed care impacted the resident.

Sources: Critical incident reports, home's investigation notes, resident's clinical notes, and interview with Director of Care.