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

Hamilton District
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Public Report

Report Issue Date: May 1, 2025

Inspection Number: 2025-1446-0002

Inspection Type:
Complaint

Licensee: Edgewater Gardens Long-Term Care Centre

Long Term Care Home and City: Edgewater Gardens Long Term Care Centre, Dunnville

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 29, 30, 2025 and May 1, 2025.

The following intake was inspected:

- Intake: #00142147 - a complaint regarding the home being a safe and secure environment and the Residents' Bill of Rights.

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

Resident Care and Support Services
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee had failed to ensure that a resident was bathed as set out in their plan of care.

Sources: Review of plan of care and interview with staff.

WRITTEN NOTIFICATION: Complaints Procedure Licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 107
Complaints procedure: licensee
s. 107. Every licensee of a long-term care home shall ensure that the written procedures required under clause 26 (1) (a) of the Act incorporate the requirements set out in section 108 of this Regulation.

The licensee has failed to comply with their Complaints Reporting procedure, which identified that if staff were unable to resolve concerns within 24 hours they were to report the concerns to their immediate manager.

In accordance with O. Reg 246/22 section 11 (1) b the licensee was required to ensure that their complaints process included an investigation into concerns and response be provided to the complainant.

Specifically, staff did not comply with the complaints reporting procedure when a resident voiced concerns and the staff member who was not able to resolve the concern and failed to notify their manager for an investigation and response.

Sources: Complaints Reporting, a review of progress notes for a resident and interview with staff.

WRITTEN NOTIFICATION: Administration of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident as prescribed.

Sources: A review of Quarterly Medication Review, physician's orders, electronic Medication Administration Record and interview with staff.