Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_661683_0007	021799-17, 009642-18, 017549-18, 020837-18, 029171-18, 029655-18, 003986-19	Complaint

Licensee/Titulaire de permis

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

Long-Term Care Home/Foyer de soins de longue durée

Idlewyld Manor
449 Sanatorium Road HAMILTON ON L9C 2A7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA BOS (683), AILEEN GRABA (682), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 23, 24, 25, 26, 29, May 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22 and 23, 2019.

This inspection was completed concurrently with critical incident inspection

#2019_661683_0008 and follow up inspection #2019_661683_0009.

The following intakes were completed during this complaint inspection:
021799-17, IL-52877-HA - related to staffing and resident care
009642-18, IL-56900-HA - related to resident care
017549-18 - related to the prevention of abuse and neglect and skin and wound
020837-18 - related to skin and wound
029171-18, IL-61395-HA - related to staffing and resident care
029655-18, IL-61464-HA - related to personal support services
003986-19, IL-64458-HA - related to staffing and nutrition and hydration.

PLEASE NOTE: A Written Notification (WN) and Compliance Order (CO) related to LTCHA, 2007, c.8, s. 6 (7) and s. 76 were identified in this inspection and have been issued in Inspection Report #2019_661683_0008, which was conducted concurrently with this inspection.
A WN and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 6 (11) (b) and a WN related to O. Reg. 79/10 s. 101 (1) (3) were identified in this inspection and have been issued in Inspection Report #2019_661683_0008, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director(s) of Nursing (DON), the Manager of Food Services, the Assistant Food Service Manager, the Manager of Recreation and Volunteer Services, the Manager of Facilities, the Registered Dietitian (RD), the Resident Assessment Instrument (RAI) Coordinator, the Nursing Administrative Assistant, the Nurse Practitioner (NP), registered staff, Personal Support Workers (PSW), recreation staff, residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed the complaints log, reviewed meeting minutes, reviewed program evaluation records, reviewed staffing records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident (i) 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, (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented, and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint log #029655-18 / IL-61464-HA was submitted to the Director on an identified date, related to plan of care.

i) A clinical record review indicated resident #003 had an area of altered skin integrity. A progress note from an identified date indicated the area of altered skin integrity resolved once an identified intervention was discontinued. A subsequent progress note indicated that the registered dietitian (RD) identified in their quarterly assessment that resident #003's skin was intact. A review of the policy #RC-08-03-03, titled "Wound and Skin Care Consent," last revised on an identified date, stated the following: "The skin care and wound care treatment plan for each resident with altered skin integrity shall be developed in consultation with: registered dietitian." Further record review did not include an

assessment of the area of altered skin integrity with a clinically appropriate tool designed for skin and wound assessment between identified dates. In addition, there were no dietary referrals initiated between the identified dates, in relation to resident #003's altered skin integrity. Inspector #583 reviewed polices with Director of Nursing (DON) #101 and assessments completed by the RD, related to change in need, no procedures or directions were found related to how the RD would be notified of alterations in skin integrity or who would be responsible for this role.

During an interview on an identified date, Registered Practical Nurse (RPN) #114 confirmed that there were no assessments of resident #003's altered skin integrity using a clinically appropriate tool between the identified dates. During an interview on an identified date, RD #106 confirmed that a dietary referral was not initiated between the identified dates, related to altered skin integrity and that they did not assess the resident. During an interview on an identified date, the DON stated that the home did not assess resident #003's altered skin integrity with a clinically appropriate tool designed for skin and wound assessment or initiate a dietary referral to assess altered skin integrity for resident #003 between the identified dates.

ii) A clinical record review included a progress note written by RPN #107, that stated on an identified date, resident #003 had an identified number of areas of altered skin integrity. A review of the policy #RC-08-03-07, titled "Prevention of Wounds," last revised on an identified date, stated the following: "Assess and document each area on Point Click Care (PCC), in progress notes under Initial Skin and Wound note and on skin/wound assessment on discovery of the area and at least weekly in progress notes." Further review included a progress note from an identified date, which identified that RPN #107 assessed resident #003's altered skin integrity. In addition, there were no dietary referrals initiated for resident #003 in relation to the altered skin integrity or further weekly skin assessments. A review of the electronic medical record indicated that an identified intervention was started in relation to the resident's altered skin integrity. On an identified date, a progress note indicated that resident #003 had a procedure related to their altered skin integrity. During an interview on an identified date, DON #101 stated that the home did not assess resident #003's altered skin integrity with a clinically appropriate tool designed for skin and wound assessment upon discovery as per their home's policy until an identified number of days later. The DON also stated weekly assessments were not completed between identified dates and were clinically indicated for the ongoing altered skin integrity. During an interview on an identified date, RD #106 confirmed that they did not receive a referral for resident #003 or assess the resident related to altered skin integrity between the identified dates. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

A complaint log #009642-18 was submitted to the Director on an identified date, related to assessment of resident #005 and their plan of care.

A clinical record review indicated resident #005 was at an identified nutritional risk related to identified diagnoses and they developed altered skin integrity in identified areas. There were physician orders related to the areas of altered skin integrity. A progress note from an identified date indicated that there was a change in resident #005's altered skin integrity in an identified area. A review of the policy #RC-08-03-03 titled "Wound and Skin Care Consent," last revised on an identified date, stated the following: "The skin care and wound care treatment plan for each resident with altered skin integrity shall be developed in consultation with: registered dietitian."

Further clinical record review did not include any documentation related to resident #005 and dietary referrals/assessments for altered skin integrity between identified dates.

During an interview on an identified date, RPN #107 could not provide evidence that dietary referrals were initiated in relation to resident #005's altered skin integrity. During an interview on an identified date, the RD stated that they did not receive dietary referrals in relation to resident #005's altered skin integrity that was identified on a specific date. During an interview on an identified date, DON #101 stated that dietary referrals were not initiated by registered staff for resident #005's altered skin integrity that developed on an identified date. The DON #101 stated that the home did not ensure that when resident #005 exhibited altered skin integrity, they were assessed by a registered dietitian. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure resident #004's area of altered skin was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) A complaint was received that identified concerns related to the management of resident #004's skin and wounds. The resident's clinical records were reviewed between identified dates. A review of resident #004's clinical records was completed with DON

#101 on an identified date and it was confirmed that an identified number of areas of altered skin integrity were not assessed weekly by a member of the registered nursing staff.

In an interview with DON #101 it was confirmed after reviewing resident #004's clinical record between the identified dates, that all areas of skin alteration were not reassessed weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument designed for skin and wound assessment when indicated.

B) Upon review of clinical records in PCC and after conversations with registered nursing staff it was shared that three tools were being used by the registered nursing staff to assess areas of altered skin integrity:
- Skin and Wound Assessment v1 tool found in the Assessment section of PCC.
- Initial Skin and/or Wound Noted followed by the Weekly or Change in Wound Assessment tool found in the progress note section of PCC.
RPN #125 shared it was their understanding that the "Skin and Wound Assessment v1" was to be used and RPN #142 shared it was their understanding that the "Initial Skin and/or Wound Note followed by the Weekly or Change in Wound Assessment" tools were to be used for skin and wound assessments. Inspector #583 and RPN #142 tried to locate the skin and wound policy for direction in multiple areas of the home and were unsuccessful. Other registered staff confirmed they were not aware where the policies were located and did not have electronic access.

Clinical records documented by RPN #114 included completed skin and wound assessments in a progress note titled "Wound Protocol." In a conversation with RPN #114 it was shared that they did not know where to locate the skin and wound polices and did not have electronic access.

The skin and wound polices were located in the DON's offices, and it was identified some of the staff on the management team had electronic access to the home's policies. The Inspector with DON #101 reviewed the policy #RC-08-03-04, titled "Treatment of Wounds," last revised August 2016, which directed staff to use the "Idlewyld Manor Wound Assessment Tool" to treat areas of skin breakdown or redness. The "Wound Staging, Assessment and Documentation," policy #RC-08-03-10, last revised February 2017, directed staff to "document each area on PCC, in progress notes under "Initial Skin and Wound Note" and on "Skin/Wound Assessment" on discovery of the area and at least weekly in progress notes." It remained unclear which clinically appropriate assessment instrument specifically designed for skin and wound assessment was/were

to be used at the time of the inspection. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work and that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A review of complaints log #021799-17, #029171-18 and #003986-19 identified concerns related to care not being provided due to the home working with fewer staff than the scheduled staffing complement.

In interviews with the Administrator on identified dates, they acknowledged that there was no documented back-up plan for nursing and personal care staffing that addressed situations when staff could not come to work, but they indicated that staff were aware of what to do. The Administrator further acknowledged that the staffing plan was not evaluated and updated at least annually in accordance with evidence-based practices or prevailing practices. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work and that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) A review of complaint log #029171-18, which was submitted to the Director on an identified date, identified concerns related to residents not receiving baths due to the home being short staffed. Specifically, the complaint identified that resident #009 missed their bath on an identified date.

A review of the written plan of care for resident #009, last reviewed on an identified date, indicated that they required an identified level of assistance with transfers and bathing. A review of the Point of Care (POC) documentation for an identified time period identified a specific number of days where the resident did not have their scheduled bath. There was no documentation that the resident refused the identified baths or that their baths were made up.

In an interview with DON #101 on an identified date, they acknowledged that resident #009 missed their scheduled baths on the identified dates and those baths were not made up and confirmed that resident #009 was not bathed twice a week during the identified time period.

B) A review of complaints log #021799-17 and #003986-19, submitted to the Director on identified dates, indicated concerns related to residents not receiving baths due to the home being short staffed. Specifically, complaint log #003986-19 identified that the home was short staffed during an identified time period.

i) A review of the written plan of care for resident #011, last reviewed on an identified date, indicated that they required an identified level of assistance with transfers and bathing. A review of the POC documentation for an identified time period indicated that the resident did not have their scheduled bath on identified dates, nor was there documentation that the resident refused their bath or that their bath was made up, on the identified dates.

In an interview with DON #101 on an identified date, they acknowledged that resident #011 missed their scheduled baths on the identified dates, and those baths were not

made up. They confirmed that resident #011 was not bathed twice a week during the identified time period.

ii) A review of the written plan of care for resident #012, last reviewed on an identified date, indicated that they required an identified level of assistance with bathing. A review of POC documentation from an identified time period indicated that the resident did not receive their scheduled bath on identified dates, and there was no documentation that the resident refused their bath or that their bath was made up.

In an interview with DON #101 on an identified date, they acknowledged that resident #012 missed their scheduled baths on the identified dates, and those baths were not made up. They confirmed that resident #012 was not bathed twice a week by the method of their choice on the identified dates.

C) A review of complaints log #021799-17, #029171-18 and #003986-19 identified concerns related to residents not receiving baths due to the home being short staffed. In an interview with PSW #126 on an identified date, they indicated that because they worked with fewer staff than the planned staffing complement on the identified shift, the scheduled baths did not get done.

i) A review of the written plan of care for resident #019, last reviewed on an identified date, indicated that they required an identified level of assistance with bathing and a review of the bath assignment list identified that the resident was to have a bath on an identified shift on two identified days each week. The POC documentation from an identified time period was reviewed and there was no documentation that the resident received their bath on an identified date, nor was there documentation that the resident refused their bath, or that their missed bath was made up.

In an interview with PSW #126 on an identified date, they confirmed that resident #019's bath was not done on an identified date because they worked with fewer staff than in their scheduled staff complement. When asked if there was a process in place to ensure that missed baths were made up, PSW #126 identified that there was not, and indicated that if a resident missed their bath they had to wait until their next scheduled one.

In an interview with resident #019 on an identified date, they indicated that they were scheduled to have a bath on identified days and they indicated that they did not always receive their bath if the scheduled number of staff were not working. They identified that staff would sometimes come in their room and indicate that they were not doing any

baths that day because they were working with fewer staff than the scheduled complement. Resident #019 expressed concerns around whether or not they would get their scheduled baths.

In an interview with DON #101 they acknowledged that resident #019 missed their scheduled bath on an identified date, and that bath was not made up. They confirmed that resident #019 was not bathed twice a week.

ii) A review of the written plan of care for resident #020, last reviewed on an identified date, indicated that they required an identified level of assistance with transfers and bathing. The POC documentation from an identified time period was reviewed and there was no documentation that the resident received their bath on an identified date, nor was there documentation that the resident refused their bath, or that their missed bath was made up.

In an interview with PSW #126 on an identified date, they confirmed that resident #020's bath was not done on an identified date because they were not working with the planned number of staff. When asked if there was a process in place to ensure that missed baths were made up, PSW #126 identified that there was not, and indicated that if a resident missed their bath they had to wait until their next scheduled one.

In an interview with resident #020 on an identified date, they indicated that sometimes their baths were missed because the scheduled number of staff were not working. The resident identified their missed bath on an identified date, and indicated that it upset them when their baths were missed. Resident #020 identified that they received their next scheduled bath, but expressed concern around whether or not they would get their scheduled baths.

In an interview with DON #101 on an identified date, they acknowledged that resident #020 missed their scheduled bath on an identified date, and that bath was not made up. They confirmed that resident #020 was not bathed twice a week.

iii) A review of the written plan of care for resident #021, last reviewed on an identified date, indicated that they required an identified level of assistance with transfers and bathing. The POC documentation from an identified time period was reviewed and there was no documentation that the resident received their bath on two identified dates, nor was there documentation that the resident refused their baths, or that their missed baths were made up.

In an interview with PSW #126 on an identified date, they confirmed that resident #021's bath was not done on an identified date, because they worked with fewer staff than in the scheduled staff complement. They identified that they worked with fewer staff than in the scheduled staff complement on a subsequent identified date, as well, and that resident #021's scheduled bath was not done. When asked if there was a process in place to ensure that missed baths were made up, PSW #126 identified that there was not, and indicated that if a resident missed their bath they had to wait until their next scheduled one.

In an interview with DON #101 on an identified date, they acknowledged that resident #021 missed their scheduled baths on two identified dates, and those baths were not made up. They confirmed that resident #021 was not bathed twice a week. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for each resident set out (c) clear direction to staff and others who provided direct care to the resident.

A complaint log #029655-18 / IL-61464-HA was submitted to the Director on an identified date, related to plan of care.

A clinical record review indicated that resident #003 had an identified diagnosis and an identified cognitive performance scale (CPS) score. The plan of care identified that specific care was to be provided on an identified day of the week. A progress noted identified specific instructions as to what the resident was not to do on identified days when identified care was being provided. A review of the complaint binder/log included a PSW shift report that indicated on an identified date, care was provided to the resident that was not consistent with what they were supposed to have as directed by an identified document. During an interview on an identified date, PSW #108 stated that they reviewed the plan of care, which could include documents such as the above noted document, to determine care needs of a resident. During an interview on an identified date, DON #101 stated that the identified care should not have been provided to the resident on the identified date. During an interview on an identified date, staff #115 confirmed that the plan of care did not set out clear direction to staff regarding the identified care for resident #003. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A complaint log #029655-18 / IL-61464-HA was submitted to the Director on an identified date, related to plan of care.

A clinical record review indicated that resident #003 had an identified diagnosis and an identified CPS score. A progress note from an identified date indicated that the resident had areas of altered skin integrity. A subsequent progress note from an identified dated stated specific directions for care from an identified individual. A review of the electronic medication administration record (EMAR) indicated that a specific intervention was started for the resident's altered skin integrity. A progress note from an identified date indicated specific directions for care for resident #003 on identified days. A review of the plan of care from an identified date did not include the specific directions for care from the resident's SDM. POC documentation indicated the resident received specific care on an identified number of days that was inconsistent with the preferences of the identified individual.

During an interview on an identified date, RPN #102 stated that registered staff updated the plan of care at whenever there was a change. During an interview on an identified date, staff #115 stated that the identified individual's preferences related to specific care area for resident #003 were not added to the plan of care.

The home did not ensure that the care set out in the plan of care based on an assessment of resident #003 and the needs and preferences of that resident. [s. 6. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that interventions related to personal care and activities of daily living for resident #003 completed by PSW staff were documented.

A complaint log #029655-18 / IL-61464-HA was submitted to the Director on an identified date, related to plan of care.

A clinical record review indicated that resident #003's plan of care last reviewed on an identified date, included a focus for an identified care area, which included specific steps to take during care related to an identified diagnosis. A review of the Resident Care Manual; Documentation Assignment; RC-01-07-10 last revised on an identified date, stated:
"It is the expectation that all staff will complete their documentation on Point of Care prior to the end of their shift."

Further review of a PSW shift report found in the complaint binder/log identified that resident #003 was provided care that was inconsistent with the directions in their plan of care on an identified date. A review of the POC tasks did not include any documentation or signatures that indicated that any care was provided to resident #003 in the identified area on the identified date. During an interview on an identified date, the DON #101 stated it was the expectation that PSW staff documented interventions and care provided into POC during their shift. The DON #101 also confirmed that the PSW shift reports were a communication tool and were not part of the resident's record. The DON #101 confirmed that documentation regarding resident #003's care in the identified area, on the identified date, was missing and the home did not ensure that resident #003's interventions related to personal care were documented. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, that included: the type of action taken to resolve the complaint, including the date of the action, timeframes for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

While inspecting complaint log #020837-18 it was identified that a written complaint was submitted to the Administrator on an identified date related to resident #010. The Administrator subsequently forwarded the complaint to the Director. A review of the complaint indicated several areas of concern related to the care of the resident.

At the time of this inspection the Administrator verified they were unable to provide a documented record of the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; or any response made in turn by the complainant. [s. 101. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 217. The licensee shall ensure that there is a designated lead for the training and orientation program. O. Reg. 79/10, s. 217.

Findings/Faits saillants :

1. The licensee failed to ensure that there was a designated lead for the training and orientation program.

During the course of the inspection a number of staff were interviewed to obtain information about the home's training and orientation program and records were reviewed. It was identified a number of different staff were involved in components of the program but no specific individual could be identified as the designated person who was leading the program. In an interview with the Administrator on an identified date, it was confirmed the home did not have a designated lead for the training and orientation program. [s. 217.]

Issued on this 29th day of July, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683), AILEEN GRABA (682), KELLY HAYES (583), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2019_661683_0007
Log No. / No de registre :	021799-17, 009642-18, 017549-18, 020837-18, 029171-18, 029655-18, 003986-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 16, 2019
Licensee / Titulaire de permis :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Hastings

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Idlewyld Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with Ontario Regulation 79/10 s. 50 (2).

Specifically, the licensee must:

1. Ensure that resident #003 and all other residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

2. Ensure the home's skin and wound policy contains clear direction as to when it is clinically indicated for registered nursing staff to complete a weekly reassessment of altered skin integrity and what clinically appropriate assessment instrument is required to be used.

3. Develop and implement an auditing process, at a frequency determined by the home, to ensure that residents with altered skin integrity are reassessed weekly when clinically indicated. The home is to maintain records of the audits completed and is to document what action was taken if/when weekly reassessments were not done.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident (i) 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, (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented, and (iv) was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A complaint log #029655-18 / IL-61464-HA was submitted to the Director on an identified date, related to plan of care.

i) A clinical record review indicated resident #003 had an area of altered skin integrity. A progress note from an identified date indicated the area of altered skin integrity resolved once an identified intervention was discontinued. A

subsequent progress note indicated that the registered dietitian (RD) identified in their quarterly assessment that resident #003's skin was intact. A review of the policy #RC-08-03-03, titled "Wound and Skin Care Consent," last revised on an identified date, stated the following: "The skin care and wound care treatment plan for each resident with altered skin integrity shall be developed in consultation with: registered dietitian." Further record review did not include an assessment of the area of altered skin integrity with a clinically appropriate tool designed for skin and wound assessment between identified dates. In addition, there were no dietary referrals initiated between the identified dates, in relation to resident #003's altered skin integrity. Inspector #583 reviewed polices with Director of Nursing (DON) #101 and assessments completed by the RD, related to change in need, no procedures or directions were found related to how the RD would be notified of alterations in skin integrity or who would be responsible for this role.

During an interview on an identified date, Registered Practical Nurse (RPN) #114 confirmed that there were no assessments of resident #003's altered skin integrity using a clinically appropriate tool between the identified dates. During an interview on an identified date, RD #106 confirmed that a dietary referral was not initiated between the identified dates, related to altered skin integrity and that they did not assess the resident. During an interview on an identified date, the DON stated that the home did not assess resident #003's altered skin integrity with a clinically appropriate tool designed for skin and wound assessment or initiate a dietary referral to assess altered skin integrity for resident #003 between the identified dates.

ii) A clinical record review included a progress note written by RPN #107, that stated on an identified date, resident #003 had an identified number of areas of altered skin integrity. A review of the policy #RC-08-03-07, titled "Prevention of Wounds," last revised on an identified date, stated the following: "Assess and document each area on Point Click Care (PCC), in progress notes under Initial Skin and Wound note and on skin/wound assessment on discovery of the area and at least weekly in progress notes." Further review included a progress note from an identified date, which identified that RPN #107 assessed resident #003's altered skin integrity. In addition, there were no dietary referrals initiated for resident #003 in relation to the altered skin integrity or further weekly skin assessments. A review of the electronic medical record indicated that an

identified intervention was started in relation to the resident's altered skin integrity. On an identified date, a progress note indicated that resident #003 had a procedure related to their altered skin integrity. During an interview on an identified date, DON #101 stated that the home did not assess resident #003's altered skin integrity with a clinically appropriate tool designed for skin and wound assessment upon discovery as per their home's policy until an identified number of days later. The DON also stated weekly assessments were not completed between identified dates and were clinically indicated for the ongoing altered skin integrity. During an interview on an identified date, RD #106 confirmed that they did not receive a referral for resident #003 or assess the resident related to altered skin integrity between the identified dates. [s. 50. (2) (b) (i)] (682)

2. 3. The licensee failed to ensure resident #004's area of altered skin was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

A) A complaint was received that identified concerns related to the management of resident #004's skin and wounds. The resident's clinical records were reviewed between identified dates. A review of resident #004's clinical records was completed with DON #101 on an identified date and it was confirmed that an identified number of areas of altered skin integrity were not assessed weekly by a member of the registered nursing staff.

In an interview with DON #101 it was confirmed after reviewing resident #004's clinical record between the identified dates, that all areas of skin alteration were not reassessed weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument designed for skin and wound assessment when indicated.

B) Upon review of clinical records in PCC and after conversations with registered nursing staff it was shared that three tools were being used by the registered nursing staff to assess areas of altered skin integrity:
- Skin and Wound Assessment v1 tool found in the Assessment section of PCC.
- Initial Skin and/or Wound Noted followed by the Weekly or Change in Wound Assessment tool found in the progress note section of PCC.
RPN #125 shared it was their understanding that the "Skin and Wound

Assessment v1" was to be used and RPN #142 shared it was their understanding that the "Initial Skin and/or Wound Note followed by the Weekly or Change in Wound Assessment" tools were to be used for skin and wound assessments. Inspector #583 and RPN #142 tried to locate the skin and wound policy for direction in multiple areas of the home and were unsuccessful. Other registered staff confirmed they were not aware where the policies were located and did not have electronic access.

Clinical records documented by RPN #114 included completed skin and wound assessments in a progress note titled "Wound Protocol." In a conversation with RPN #114 it was shared that they did not know where to locate the skin and wound polices and did not have electronic access.

The skin and wound polices were located in the DON's offices, and it was identified some of the staff on the management team had electronic access to the home's policies. The Inspector with DON #101 reviewed the policy #RC-08-03-04, titled "Treatment of Wounds," last revised August 2016, which directed staff to use the "Idlewyld Manor Wound Assessment Tool" to treat areas of skin breakdown or redness. The "Wound Staging, Assessment and Documentation," policy #RC-08-03-10, last revised February 2017, directed staff to "document each area on PCC, in progress notes under "Initial Skin and Wound Note" and on "Skin/Wound Assessment" on discovery of the area and at least weekly in progress notes." It remained unclear which clinically appropriate assessment instrument specifically designed for skin and wound assessment was/were to be used at the time of the inspection. [s. 50. (2) (b) (iv)] (583)

The severity of this issue was determined to be a level 2 as there minimal risk to the residents. The scope of the issue was a level 2 as it related to two of three residents reviewed. The home had a level 3 compliance history as they had on-going non-compliance with this section of O. Reg 79/10 that included:
• Voluntary Plan of Correction (VPC) served on September 23, 2016 (2016_343585_0013) (583)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office