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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2019	2019_555506_0011	013758-19, 014601-19, 020036-19	Critical Incident System

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

LESLEY EDWARDS (506), GILLIAN HUNTER (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 29, 30, November 4, 5, 6, 7, 14, 15, 18, 19, 20, 21 and 22, 2019.

Critical Incident Inspection Log #013758-19 - related to falls prevention
Critical Incident Inspection Log #014601-19- related to falls prevention
Critical Incident Inspection Log #020036 -19- related to unexpected death

This inspection was completed concurrently with follow up inspection report #2019_555506_0012.

A Written Notice, Compliance Order and Director Referral related to LTCHA, 2007, c. 8, s. 19 (1) and s. 8 (1) (b) was identified in this inspection and has been issued in Inspection Report 2019_555506_0012, November 2019, which was conducted concurrently with this inspection.

A Voluntary Plan of Correction related to LTCHA, 2007, c.8, r. 229. (4), identified in a concurrent inspection #2019_555506_0012 (Log # 014887-19) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nurses (DON's), Special Projects Administrator, Nursing Administration Assistant, Resident Assessment Instrument (RAI) Co-ordinator, Agency support staff, Assistant Food Service Manager, Corporate Staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed clinical records, policies and procedures, investigation notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **8 WN(s)**
- **5 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to participate fully in the development, implementation, review and revision of their plan of care.

The licensee submitted a CIS report #2931-000029-19 on an identified date in October 2019, identifying an unexpected death of resident #001 on an identified date in October 2019.

i. On an identified date in October 2019, resident #001 had a concern and needed assistance, RPN #108 attended to the resident. After a short time resident #001 still had the same concern and requested an intervention. At this time, RPN #108 called RN #109 to come and see the resident and notified them that resident #001 wanted an intervention. RN #109 went to go and see the resident with RPN #108 and resident #001 expressed to RN #109 that they wanted an intervention. RN #109 explained to the resident if they wanted the intervention they would have to wait a long time. Resident #001 again expressed that they wanted this intervention and RN #109 did not provide the intervention. RN #109 confirmed through an interview with the licensee that they did not allow the resident to participate fully in their plan of care and did not respect the rights of resident #001.
ii.On an identified date in October 2019, during the shift resident #001 requested an intervention on several occasions. PSW #124 in an interview on an identified date in November 2019, with the Long Term Care (LTC) inspector confirmed that they reported to RPN #104 that resident #001 wanted an intervention and RPN #104 asked PSW #124 to provide an intervention. PSW #125 also confirmed through an interview with the LTC inspector on an identified date in November 2019, that they reported to RPN #104 that the resident expressed their wishes and wanted an intervention and this request was heard by PSW #126 as well. RPN #104 responded by stating they could not provide the intervention. RPN #104 did not allow the resident to fully participate in their plan of care and respect the rights of resident #001 and provided the intervention.
An interview with DON #101and the Administrator on an identified date November 2019, confirmed that resident #001's rights were not fully respected when they continually expressed concerns to staff and requested an intervention on numerous occasions and was not able to participate fully in the development, implementation, review and revision of their plan of care. [s. 3. (1) 11.]

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 following rights of residents are fully respected and promoted: every resident has the right to participate fully in the development, implementation, review and revision of their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports.

Section 24 of the Act requires the licensee to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may have occurred shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019. 2007.

Review of the home's policy Non-Abuse of Residents, effective date August 2019, did not include an explanation of the duty under section 24 of the Act to make mandatory reports. Interview with the Administrator on an identified date in November 2019, confirmed that the home's Non-Abuse of Residents policy effective August 2019, was the home's most current version of the policy and that it did not reflect all of the information in Section 24 of the Act, as required. The policy did not include all incidents outlined under section 24 of the Act, required to make mandatory reports. [s. 20. (2)]

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 policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

Review of progress notes dated November 2019, documented by RPN #140 identified that resident #012's visitor was seen and heard by staff requesting an inappropriate gesture. PSW #141 reported to RPN #140 and RN #105. During an interview with RPN #140 and RN #105 on an identified date in November 2019, confirmed that they reported this incident to DON #102 that shift; however, they did not report the alleged abuse to the Director. In an interview with the Administrator on an identified date in November 2019, confirmed that they felt that the incident did not meet the definition of abuse after the investigation had been completed, but confirmed that they did not immediately report or have reported the suspicion of alleged abuse to the Director. [s. 24. (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 when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

The licensee failed to ensure that in a home with a licensed bed capacity of 97 beds or more, the home's Administrator worked regularly in that position on site at least 35 hours per week.

Idlewyld Manor is a 192 licensed bed long term care home. At the time of the inspection it was identified that the Administrator was not working and had been off for approximately three weeks. During interviews with staff identified that the Administrator was also off for an extended period of time during the summer. Interviews with staff confirmed that the DON's were in charge of the home. Interviews with DON #001 and DON #002 confirmed that neither one have their Administrators credentials. In an interview with the Administrator on an identified date in November 2019, they confirmed that they were off for an extended period of time starting in June 2019 and returned back to full time duties on a specified date in August 2019, during this time they were available by phone and the Special Projects Administrator from Thrive was assigned to the home sometime in July 2019. In an interview with Special Projects Administrator on an identified date in November 2019, confirmed that they were put in the home on an identified date in July 2019, but were not there to complete the Administrators role but were assigned to support the home with compliance and culture development. During this inspection it was identified that the Administrator had not worked the required number of hours on site at the home. [s. 212. (1) 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 in a home with a licensed bed capacity of 97 beds or more, the home's Administrator worked regularly in that position on site at least 35 hours per week, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

While observing medication administration pass on an identified date in November 2019, it was noted that RPN #142, consistently failed to wash or sanitize their hands between administering medications to individual residents. At this time, it was also observed that there was a bottle of hand sanitizer in a bin located on the left side of the medication cart.

During a discussion with DON #101 on the above noted date, they confirmed that it was their expectation that staff wash their hands before preparing medication and after administration of medication. DON #101 also provided the licensee's policy "Medication Administration Pass", identified as #4.6 with a revised date of August 2019, which directed, as part of the procedure, that staff were to "wash/sanitize hands between the administration of medications to residents".

The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program when it was observed that RPN #142 failed to wash/sanitize their hands while administering medications to residents during the medication pass on an identified date in November 2019. (Inspector #129) [s. 229. (4)]

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 all staff participated in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #6: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to resident #001as specified in their plan.

Resident #001's clinical record confirmed that resident #001's plan of care identified that resident #001 was to have a specific amount of a treatment as per the physician's order on an identified date in September 2019. It was identified during a review of the resident's progress notes that there were several times where it was documented that the resident was given the wrong amount of the treatment.

i. On an identified date in September 2019, it was documented that resident #001 was using a specified amount of the treatment. Interview with RPN #107 on an identified date in October 2019, confirmed that the resident was using a specified amount at this time and that the resident's plan of care was not followed.
ii. On an identified date in September 2019, it was documented that resident #001 was using a specified amount of the treatment. Interview with RPN #104 on an identified date in October 2019, confirmed that the resident was using a specified amount at this time and that the resident's plan of care was not followed.
iii. On an identified date in September 2019, it was documented that resident #001 was using a specified amount of the treatment. Interview with RPN #107 on an identified date in October 2019, confirmed that the resident was using a specified amount at this time and that the resident's plan of care was not followed.
iv. On an identified date in September 2019, it was documented that resident #001 was using a specified amount of the treatment. Interview with RPN #104 on an identified date in October 2019, confirmed that the resident was using a specified amount at this time and that the resident's plan of care was not followed.
v. On an identified date in September 2019, it was documented that resident #001 was using a specified amount of the treatment. Interview with RPN #107 on an identified date in October 2019, confirmed that the resident was using a specified amount at this time and that the resident's plan of care was not followed.
The licensee failed to ensure that resident #001's care was provided as specified in the resident's plan of care.

Please note: This evidence further supports compliance order (CO) #004, that was issued on July 16, 2019, related to the same section, of the O. Reg. 79/10, s. 6 (7), with a compliance due date of September 30, 2019.

This non-compliance occurred prior to the compliance due date. [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that when resident #004 had fallen, that they were assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's policy titled Fall Prevention and Management Program, section: RC-11-01-01, revised September 2019, indicated: the RPN and the RN accurately completes the post fall assessment.

On an identified date in July 2019, resident #004 had a fall and then sustained another fall on an identified date in July 2019 approximately 12 days later.

A review of the PCC Assessment history and registered staff #117, confirmed in an interview that a post fall assessment was not completed after the first fall in July 2019.

On an identified date in July 2019, resident #004 did not have a post fall assessment completed using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)] (130)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 2. An unexpected or sudden death.

Resident #001had an unexpected death on an identified date in October 2019. An interview with DON #101 on an identified date in October 2019, confirmed that the licensee did not immediately inform the Director of the unexpected death as the Critical Incident was not submitted to the Director until four days later. [s. 107. (1) 2.]

Issued on this 10th day of December, 2019

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

Original report signed by the inspector.