Ontario

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

# Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*


**Ministry of Health and Long-Term Care**
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de longue durée**
Division de la responsabilisation et de la performance du système de santé
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| **Date of inspection/Date de l'inspection** | **Inspection No/ d'inspection** | **Type of Inspection/Genre d'inspection** |
|---|---|---|
| August 11, 2011 | 2011-159120-034 | H-001931-11 Critical Incident |

**Licensee/Titulaire**

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(s)**

Bernadette Susnik, Long Term Care Homes Inspector – Environmental Health #120

## Inspection Summary / Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the above noted inspector spoke with the Administrator and Director of Care and reviewed all documents related to the critical incident.

The following Inspection Protocols were used during this inspection:

- ***Prevention of Abuse, Neglect and Retaliation***

Findings of Non-Compliance were found during this inspection.

**2 WN**

## NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avis écrit
**VPC** – Voluntary Plan of Correction/Plan de redressement volontaire
**DR** – Director Referral/Régisseur envoyé
**CO** – Compliance Order/Ordres de conformité
**WAO** – Work and Activity Order/Ordres: travaux et activités

| | |
|---|---|
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.<br><br>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.) | Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.<br><br>Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi. |

**WN #1:** ***The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 19(1).*** *Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.*

An identified resident was not protected from emotional abuse by a personal service worker (PSW) who was providing care in 2011. A co-worker witnessed a PSW leaving the resident's room after evening care and approached her with a question. While the two workers were conversing, the resident came out of their room and was observed to be physically shaking and crying and they stated "I want to go home, I'm shaking". When questioned, the resident pointed to a PSW and stated "I did not like the reception I got" from the PSW. The resident was then assisted into a chair and was told to wait for a snack. While the resident sat in the chair they continued to cry. The resident then reported to a third PSW that "they were pushed here and there and that it hurt". The resident again pointed to the PSW as the reason for their distress.

Interviews with the management staff and statements made by the witnesses revealed that the identified PSW was responsible for the resident's emotional distress. The home took follow-up measures with the resident and the staff member who was involved with the resident.

**WN #2:** ***The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 20(1).*** *Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.*

The home's Zero Tolerance of Abuse & Neglect Policy AM-02-01-08, dated March 29, 2011 and their Mandatory and Critical Incident Reporting Policy RC-05-06-03 dated May 31, 2011 were not complied with. A nurse did not immediately report an alleged incident of abuse on an identified evening in 2011 to her superiors, as per their policy AM-02-01-08. As a result, the home management staff were not able to forward the information to the Ministry of Health and Long-Term Care within required timelines.

The abuse policy states on page 2 that "staff should immediately report under the Home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1)". In the home's reporting policy RC-05-06-03, on page 1, it states that "the RN must assess the situation and inform the Executive Director or designate immediately". The nurse in charge on an identified evening in 2011 did not document or report an incident of alleged emotional abuse until the following day, later in the afternoon at which time it was forwarded to the Executive Director.

**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**

B. Summit

**Date of Report:** (if different from date(s) of inspection). Oct. 12/11