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	2011-159120-033 2011-159120-030	H-000920-11 Complaint H-001034-11 Complaint

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 complaint inspections.

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 complaints.

The following Inspection Protocols were used during this inspection:

- **Personal Support Services**
- **Continence Care and Bowel Management**
- **Dignity, Choice and Privacy**

Findings of Non-Compliance were found during this inspection.

3 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. 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. 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 O. Reg.79/10, s. 36.*** *Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.*

Findings:

A worker did not use safe positioning techniques when assisting an identified resident with their morning care. A family member of the resident witnessed a personal service worker assisting the resident in the bathroom in 2011. The resident was leaning against their assistive walker, while the worker put on their shoes. The wheels were not in the locked position. The resident's safety was compromised while in this position. The management staff of the home conducted an investigation and confirmed the observations of the family member.

WN #2: ***The licensee has failed to comply with LTCHA, 2007, S.O., 2007, c.8, s. 3(1)1.*** *Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:*

1.Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

The resident's privacy and dignity were not respected by a personal service worker. An identified resident reported to their family member, sometime in the past that a personal service worker is not always nice to them and that she is rough at times and that she intimidates them. The family member also remembers that the worker spoke inappropriately to the resident by saying "come come", as if they were a dog. The family member witnessed the worker applying shoes to the resident's feet, with the bathroom door open while they were not properly dressed. The family member reported their concerns to the management staff of the home.

The management staff of the home conducted an investigation and supported the statements provided by the resident and their family member that the resident was not treated with dignity and respect.

WN #3: ***The licensee has failed to comply with O. Reg. 79/10, s. 51(2)(c).*** *Every licensee of a long-term care home shall ensure that,*

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence.

A resident did not receive assistance from staff to manage and maintain continence. An identified resident's plan of care has specific requirements to manage and maintain their continence. At a minimum, during the day, the resident is to be toileted before and after meals and when the resident requests. A personal service worker, who was caring for the resident on a particular day in 2011, was not familiar with the resident's plan of care. When the resident requested to go to the bathroom after a meal, they were told that they would have to wait until the worker could complete duties in the dining room. As a result, the resident attempted to self transfer from the wheelchair to the toilet and subsequently fell. No injuries were sustained as a result of the self transfer. The management of the home conducted an investigation and confirmed that the resident did not receive assistance from staff to manage and maintain continence.

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. Lucas

Date of Report: (if different from date(s) of inspection).

Oct. 4/11