Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
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
Jun 10, 2021	2021_877632_0010	022004-20, 024322-20, 024439-20	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

YULIYA FEDOTOVA (632)

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): May 5, 6, 7, 10 and 13, 2021.

The following Critical Incident System (CIS) intakes were completed:
log #022004-20 - related to Medications,
log #024322-20 - related to Prevention of Abuse and Neglect,
log #024439-20 - related to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Manager of Recreation and Volunteer Services, Infection Prevention and Control (IPAC) and Informatics Manager, Privacy and Quality Office/Pandemic Lead, Social Worker, Residents' Physiotherapist (PT), Staffing Clerk, Registered Nurses (RNs), Charge Nurse #1, Charge Nurse #2, Registered Practical Nurses (RPNs), Behavioral Supports Ontario (BSO) RPN, Housekeeping and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors toured the home and completed IPAC checklist, observed residents and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 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 :

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

Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care (MLTC) related to a resident's fall resulted in injury.

During the inspection on identified dates it was observed that the resident performed specified activities in a home area's hallway without a specified assistance by the home's staff.

An RPN indicated that during the resident's specified activities in the unit the staff had to provide the specified assistance.

The resident’s current care plan indicated that the resident required specified assistance with their mobility. Review of Fall Risk and Post Fall Assessment indicated that the resident was at identified risk for falls.

A PT indicated that based on the resident's assessment, they needed specified support with their mobility.

The resident was at risk of having a fall when specified assistance was not provided by staff when the resident performed specified activity in the unit.

Sources: resident #001’s current care plan, the PT Assessment, the Fall Risk and Post Fall Assessment; observations; interviews with RPN #125 and the PT. [s. 6. (7)]

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 and ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: 11. Appropriate seating for staff who were assisting residents to eat.

During the inspection, it was observed that the home's staff were not appropriately seated while assisting a resident with their lunch meal.

The resident's written care plan was focused on specified nutrition concerns and it directed staff to provide specified assistance with eating to the resident. Feeding and Meal Assistance Policy listed specified directions to staff when the assistance with eating was provided.

An RPN confirmed that the staff was to perform specified assistance with eating to the resident.

The resident was at specified risk as a result the specified assistance with eating was not provided by staff.

Sources: resident #002's written care plan, Feeding and Meal Assistance Policy; interview with RPN #103. [s. 73. (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 and ensuring that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate seating for staff who are assisting residents to eat, to be implemented voluntarily.

WN #3: 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 :

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

A. During the inspection on an identified date in May 2021, it was observed no specified Personal Protective Equipment (PPE) was available in a PPE cart located beside identified room, which was on specified precaution protocol.

The IPAC Policy indicated that routine practices and additional precautions recommended specified PPE to be used.

An RPN indicated that the specified PPE was to be available in the PPE cart.

The residents and staff were at risk of contracting an infection as a result of no specified PPE was available in the PPE cart located near the room, which was on specified precaution protocol.

Sources: the IPAC Policy; observations; interview with RPN #124.

B. During the inspection on an identified date in May 2021, it was observed that there was no specified precaution sign posted on or near the entrance door of an identified room of an affected resident.

The IPAC Policy indicated that signage was one of the elements that comprised specified precautions.

An RPN indicated that specified precaution sign posted on or near the entrance door in the identified room should be in place.

The residents and staff were at risk of contracting an infection as a result of no specified precaution signs posted on or near the entrance door of the affected resident.

Sources: the IPAC Policy; observations; interview with RPN #123. [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 and ensuring that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

CIS report was submitted by the home to the MLTC related to the incident when a resident in the home displayed identified responsive behaviours towards staff.

The resident's written care plan indicated interventions to manage their mood state but did not identify behavioural patterns, any identified responsive behaviours and any potential behavioural triggers and variations in the resident.

Progress notes identified that on identified dates in August 2020 and in November 2020, the resident demonstrated some specified responsive behaviors towards staff.

Responsive Behaviors Policy indicated developing interventions to minimize triggers or respond effectively for specific residents and to prevent the escalation of potentially harmful or abusive situations.

PSWs, an RPN and an RN, who were familiar with the care requirements for the resident, indicated that the resident exhibited specified responsive behaviors towards staff.

The resident was at risk of exhibiting unmanageable responsive behaviors towards staff during the care as their plan of care did not identify behavioural patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Sources: resident #005's care plan, progress notes, Responsive Behaviors Policy; interviews with PSWs #113 and #116, RPN #114 and RN #127. [s. 26. (3) 5.]

Issued on this 15th day of June, 2021

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

Original report signed by the inspector.