Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: October 24, 2023	
Inspection Number: 2023-1415-0003	
Inspection Type: Critical Incident	
Licensee: Idlewyld Manor	
Long Term Care Home and City: Idlewyld Manor, Hamilton	
Lead Inspector Betty Jean Hendricken (740884)	**Inspector Digital Signature** Elizabeth J Hendricken Digitally signed by Elizabeth J Hendricken Date: 2023.11.08 11:39:33 -05'00'
Additional Inspector(s) Indiana Dixon (000767) Yuliya Fedotova (632)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 7, 8, 11, 13, 14, 15, 18 - 20, 22, 25, 27-29, 2023 and October 4, 2023.

The following intake(s) were inspected:
- Intake: #00002262 - (critical incident) related to missing resident with injury.
- Intake: #00021117 - (critical Incident) related to resident-to-resident physical abuse.
- Intake: #00094672 - (critical incident) related to falls prevention and management.

The following intake(s) were completed:
- Intake: #00085566 - (critical incident) related to falls prevention and management.
- Intake: #00022092 - (critical incident) related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Pain Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee has failed to ensure that communication and assessment methods for residents who were unable to communicate their pain or who were cognitively impaired were in place.

Rationale and Summary
A resident sustained an injury. The resident had a history of responsive behaviours. Staff failed to recognize responsive behaviours as a sign of pain.

The home's Policy, Summary of Pain Management, stated that registered staff were to respond to resident's complaints of pain, non-verbal signs of pain and anticipated pain needs immediately and assess the nature and origin of pain. The home's pain management program also included a video titled, Pain and Cognitive Impairment: Reading the Cues that instructed staff to be aware of behaviours that would indicate pain, including noisy and disruptive behaviour.

For a period of time after the resident's injury, progress notes stated that the resident continued to demonstrate responsive behaviours related to pain. As a result, the resident became weak and their health status declined.

Staff confirmed that the resident was receiving scheduled pain medication twice daily, but should have recognized responsive behaviours as signs of pain and assessed accordingly.

Failure of the home to provide communication and assessment methods for the resident who was unable to communicate their pain caused them to suffer as a result of unmanaged pain and led to a decline in health.

Sources: Resident's clinical records, interviews with staff, Idlewyld Manor Summary of Pain Management Policy (dated Feb. 17, 2017), Youtube Video Pain and Cognitive Impairment: Reading the Cues.

[740884]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

On an identified date, the Licensee failed to protect resident #003 from physical abuse by resident #002.

Rationale and Summary
For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

On an identified date, resident #002 and resident #003 had an altercation resulting in resident #003 sustaining an injury. A staff member confirmed that this would be considered physical abuse.

Sources: CI #2931-000004-23, clinical records for resident #003, staff interview
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WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The Licensee failed to ensure that a resident's pain was assessed using a clinically appropriate instrument.

A resident was cognitively impaired and had an intervention in their care plan instructing registered staff to complete pain assessments using a pain assessment tool for cognitively impaired residents as the resident was unable to verbalize their pain experience.

On several occasions registered staff used a pain assessment instrument that was not clinically appropriate for the resident.

Failure to assess the resident's pain using a clinically appropriate instrument may have contributed to a negative outcome for them.

Sources: Resident #003's clinical records, interviews with staff.
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WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.

The Licensee failed to ensure that written approaches to care were developed to meet the needs of resident #003 with responsive behaviours, including reassessment.

On an identified date, resident #003 and resident #002 had an altercation resulting in resident #003 sustaining an injury. A Responsive Behaviours Assessment was completed for resident #003 that did not identify expressed physically responsive behaviours. A review of resident #003's progress notes demonstrated that resident #003 had expressed verbally and physically responsive behaviours and the physician documented that there were ongoing concerns regarding their responsive behaviour. There was no evidence of any further assessment or reassessment of resident #003's responsive behavior.

Interviews with staff confirmed that no documented reassessment of the resident's responsive behaviour was completed.

Failure to reassess the resident's responsive behaviour led to a negative outcome for them.

Sources: Resident #003's clinical records, interviews with staff, CI #2931-000004-23
[740884]

WRITTEN NOTIFICATION: Maintenance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

The licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance in relation to the Roam Alert system in the home.

Securaband Tag User Guide (by Stanley Healthcare) indicated that it was essential monthly testing and maintenance of this product.

On an identified date, the Maintenance #two in the home indicated that monthly testing of the Roam Alert system in the home were conducted but they were unable to provide documented maintenance schedule and procedures in place for the routine, preventive and remedial maintenance in relation to Roam Alert system, which was confirmed by the Associate Administrator.

Sources: Interviews with the Maintenance #two and the Associate Administrator.
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