Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 22, 2011; Jan 4, 2012	2011_072120_0079	Critical Incident

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator and Director of Care regarding resident abuse (H-001931-11).

During the course of the inspection, the inspector(s) reviewed all documents related to the critical incident.

Note: This report is a copy of the original inspection report #2011-159120-034 for an inspection conducted on August 11, 2011. IQS was not functioning at the time and all information was collected manually. Please see original reports on the Y drive under the home name and log #H-001931-11.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following subsections:

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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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 time lines.

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.

Issued on this 4th day of January, 2012

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