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_0080	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 critical incident 2931-000025-11.(H-001396-11)

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

Note: This is a copy of the original inspection report #2011-159120-028 for an inspection conducted on August 11, 2011. IQS was not functioning at the time of inspection and all information was collected manually. Please see the originals on the Y drive under the home name and log #H-001396-11.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee did not ensure that the home was a secure environment for its residents on a particular night in the summer of 2011. An identified resident eloped from the home on a particular night, some time after 3 a.m. via the front lobby doors. The door security system was engaged and the resident knew the key code to disengage the doors. The home did not have a security policy to keep doors locked (and therefore the key pad inoperable) after administrative staff leave for the day. The resident was not identified to be missing by the home staff. A private citizen found the resident several hundred feet from the main doors at approximately 4:40 a.m. and informed the night staff. The resident was transferred to the hospital where they were diagnosed with minor hypothermia and fractured left hip.

The resident was not routinely monitored to ensure that they were safe and secure inside the building. On a particular night, the resident left their home area and sat in the lobby for a period of time prior to leaving the building. Progress notes indicate that this resident is often found sitting in the lobby at different hours of the day and night. It was well known that the resident favoured the lobby area. The resident was not checked on the night in question. Since this incident, the management of the home instituted a new policy to keep front doors locked from 9:00 p.m. to 6:00 a.m. daily.

Issued on this 4th day of January, 2012

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