Ontario

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

Rapport d'inspection prévue 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(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 14 and 15, 2011	2011-120-2931-14Apr164630	H-02852-10 - 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 – Environmental Health #120

Inspection Summary/Sommaire d'inspection

The purpose of this visit was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with the Administrator, Director of Care, Environmental Services Supervisor and housekeeping staff. During the course of the inspection, resident rooms, washrooms tub rooms, clean utility rooms, linen closets and dining rooms in 5 resident home areas and the laundry room were inspected.

The following Inspection Protocols were used:

- *Accommodation Services – Laundry*
- *Accommodation Services – Housekeeping*

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
1 VPC

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. 89(1)(c).*** As part of the organized program of laundry services under clause 15(1)(b) of the Act, every licensee of a long-term care home shall ensure that,

(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours.

Findings:

The following linen was identified to be in poor condition:

Cracked pillow surfaces identified on 16 resident beds. Thread bare and transparent bottom sheets identified on 6 resident beds and transparent pillow cases identified on pillows, on resident beds in 11 rooms. Linen in good condition was identified to be in adequate amounts in the home, however staff, both in nursing and in laundry, are not removing linen that is not in good condition from circulation when necessary. The identified linen was reported to have been removed from circulation by April 15, 2011.

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 in respect to ensuring that linen, face cloths and bath towels are maintained in a good state of repair, to be implemented voluntarily.

WN #2: The license has failed to comply with the LTCHA 2007, S.O., 2007, c. 8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

Findings:

1. The lost and found process in the home is not monitored, analyzed or evaluated to determine where improvements need to be made. Over 150 unlabelled articles of clothing were noted in the laundry room, and staff did not know when the various articles were acquired. Very little effort has been made to return these articles to residents. No proactive auditing is conducted of resident closets to determine whether or not clothing is labeled and personal care staff do not take regularly check labels before sending them to

be laundered. Complaints from residents who claim that an article has been lost are not formally documented and the home does not keep track of how many complaints are lodged or resolved.

2. The nurse call response system in the home includes a software program to track the length of time it takes for a staff member to respond to a pulled call station. During the inspection, the call log for March 16, 2011 was reviewed. It was noted that at least 6 different call stations were left to ring for longer than 20 minutes, between 4:45 and 8:05 p.m. A trend was noted that wait times tend to be longer around meal times after reviewing several different call logs for different days in March. It is not known whether or not the resident received the care that they required at that time or what the reason for the call was. The information available to the home regarding call response time was not being used at the time of the inspection. Policies and procedures have not been developed for staff as to the homes' expectations on call bell response times and timely provision of care. The management staff indicated that they are planning to institute the use of the software program soon and that management staff would be receiving training. The provision of care during busy time periods (before and after meals) would need to be monitored and evaluated to determine what improvements need to be made to the service.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**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. Lusnik
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 30/11