Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 11, 2018	2018_561583_0008	009396-18	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

KELLY HAYES (583)

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 1, 2, 3, 4, 8, 9, 10, 11, 14, 15, and May 16, 2018.

The following intakes were completed during this Critical Incident System (CIS) Inspection:
Log #009396-18-related to: prevention of abuse and neglect.

A Complaint Inspection was conducted concurrently during this CIS Inspection. In

addition to this report the following non-compliance has been issued in Inspection 2018_743536_0006, related to log #009890-18:

LTCH Act, 2007, s. 19(1), Director Referral (DR),related to the home failing to ensure all residents were protected from neglect.
LTCH Act, 2007, s. 23(1)(a)(b), Compliance Order (CO), related to the home failing to ensure that every suspected incident of abuse was immediately investigated and appropriate action was taken in repose to every such incident.
LTCH Act, 2007, s. 24(1), Voluntary Plan of Correction (VPC), related to persons who had reasonable grounds to suspect that abuse of a resident had occurred immediately reported the suspicion and the information upon which is was based to the Director.
O. Reg. 79/10, s. 54(b), Compliance Order (CO), related to the home failing to ensure steps were taken to minimize the risk of potentially harmful interactions between residents.
O. Reg 79/10, s. 98, Compliance Order (CO), related to the home failing to ensure that the appropriate police force was immediately notified of any suspected incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

During the course of the inspection, the inspector(s) spoke with residents, family members, reception staff, business office staff, Registered Nurses (RN's), Registered Practical Nurses (RPN's), Personal Support Workers (PSW's), the Behavioural Support Ontario staff (BSO), Resident Assessment Instrument (RAI) Co-ordinator, Manager of Program Developement, Director of Nursing (DON) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, completed observations and reviewed the home's investigation notes, employee files, training records, complaint logs, staffing schedules, clinical documentation, medical records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 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	Legendé 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to a resident under a program, including assessments and interventions were documented.

On an identified date in 2018 a Critical Incident System (CIS) was submitted report an incident of alleged resident to resident abuse between resident #011 and #012.

An interview was completed with RPN #134 and it was shared they completed a physical assessment of resident #011 and directed PSW staff to provide increased monitoring of resident #011 and #012 and the information related to the incident was shared to oncoming registered staff at shift change.

Resident #011's clinical records were reviewed and it was noted there was no documented physical assessment of the resident. It was shared by RPN #134 that they did not document the physical assessment they completed of resident #011 at the time of the incident.

During interviews completed with RPN #135 and #134 and through a review of the plan of care it was identified that resident #011's Substitute Decision Maker (SDM) was notified about the incident one day after it occurred but it was not documented in the clinical records.

On the day of the incident and the day following RPN #134 and #135 shared that PSW's were made aware of the incident and staff discussed the incident during shift changes to oncoming staff. Staff were directed to provide increased monitoring of resident #011 and #012. Resident #011's and #012's clinical records were reviewed and it was noted there was no documentation of the intervention to provided increased monitoring in either resident's plan of care. It was shared by RPN #134 and #135 that this was communicated by word of mouth.

Actions taken with respect to resident #011's assessment and interventions for resident #011 and #012 related to the incident that occurred on an identified date were not documented.

Please note: this non-compliance was issued as a result of Critical Incident Inspection (CIS) log #009396-18. [s. 30. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was notified within 12 hours upon the licensee becoming aware of a suspected incident of abuse of a resident.

The home's policy titled: "Zero Tolerance of Abuse and Neglect", stated:
The Home will notify the resident's SDM, if any, and any other person the resident specifies:
a) Immediately upon the Home becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that has the potential to be detrimental to the resident's health and well-being.
b) Within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On an identified date in 2018 the home reported an incident of alleged resident to resident abuse between resident #011 and #012.

During interviews completed with RPN #135 and #134 it was identified that resident #011's SDM phoned the home the day after the incident to share other non-related information to the home. At this time RPN #135 notified the SDM of the incident. RPN #134 confirmed they did not notify the SDM at the time of the suspected incident. After review of the investigation notes, resident #011's clinical records and interviews with staff it was confirmed that #011's SDM was not notified of a suspected incident of abuse within 12 hours of the home becoming aware.

Please note: this non-compliance was issued as a result of Critical Incident Inspection (CIS) log #009396-18. [s. 97. (1) (b)]

Issued on this 20th day of September, 2018

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

Original report signed by the inspector.