Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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
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119, rue King Ouest 11iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_661683_0009	030800-18	Follow up

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

LISA BOS (683), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 23, 24, 25, 26, 29, May 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22 and 23, 2019.

This inspection was completed concurrently with complaint inspection #2019_661683_0007 and critical incident inspection #2019_661683_0008.

**The following intakes were completed during this follow up inspection:
Log #030800-18 - related to compliance order (CO) #001 from inspection #2018_695156_0007 regarding O. Reg. 79/10 s. 131 (2).**

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10 s. 131 (1) and a Written Notification, Compliance Order and Director Referral related to O. Reg. 79/10 s. 131 (2), identified in concurrent inspection #2019_661683_0008 (log #007426-19, CIS #2931-000012-19) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director(s) of Nursing (DON), the Manager of Recreation and Volunteer Services, the Resident Assessment Instrument (RAI) Coordinator, the Nursing Administrative Assistant, the Nurse Practitioner (NP), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records and observed residents during the provision of care.

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **1 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	Légende 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that drugs were administered to resident #027 in accordance with the directions for use specified by the prescriber.

While inspecting Critical Incident (CI) log #007426-19 related to Critical Incident System (CIS) #2931-000012-19, the following was identified:

On an identified date, Registered Practical Nurse (RPN) #139 administered identified medications to resident #027 that were not prescribed for the resident.

Resident #027's clinical record, a Medication Incident Report and a conversation with DON #101 confirmed that resident #027 was administered medications that were not prescribed for them. [s. 131. (1)]

2. The licensee failed to ensure that an identified number of drugs resident #023's physician specified be administered were administered on an identified date.

While completing follow-up inspection log #030800-18 related to compliance order (CO) #001 from Inspection #2018_695156_0007, which ordered the licensee to ensure that resident #001 and any other residents were administered drugs in accordance with the directions for use specified by the prescriber, the following was identified:

Please note; resident #001 identified in the above noted order was identified as resident #023 in this Follow-Up inspection.

A review of resident #023's Medication Administration Record (MAR) subsequent to the above noted order compliance due date of December 31, 2018, noted that in an identified month staff had not signed to indicate that identified medications scheduled for administration at an identified time, had been administered.

During a conversation with DON #101 on an identified date, they reviewed the above noted MAR and confirmed that the medications had not been signed for as having been administered to the resident at an identified time on an identified date.

On an identified date, DON #101 provided a "Physician Order Audit Report" to Inspector #682 that confirmed the identified medications were not administered to resident #023.

DON #101, clinical documentation and the "Physician Order Audit Report" confirmed that resident #023 was not administered the identified drugs in accordance with the directions specified by their physician who prescribed the drugs. [s. 131. (2)]

3. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that an identified number of drugs resident #033's physician specified be administered were administered on an identified date.

A review of resident #033's Medication Administration Record (MAR) indicated there was no documentation on the MAR to verify that the resident was administered identified medications at an identified time, on an identified date.

A review of clinical notes made by registered staff confirmed that there were no clinical notes made on the identified date to explain why resident #033's scheduled medications had not been administered.

In conversation with DON #101 it was verified that staff had not signed the MAR to indicate the medications scheduled had been administered at an identified time to the resident. The DON provided a "Physician's Order Audit Report" from the computerized document system which verified that all of the above noted medications were not administered.

On an identified date, a conversation was held with RPN #146 who verified they worked

on an identified date, and would have been responsible for the administration of resident #033's medication, but they were unable to recall the reason the medications were not signed for on the MAR to indicate they had been administered.

During a conversation with resident #033 on an identified date, they recalled the situation where they did not receive their medications because prior to this incident there was another incident where their medications were not administered as prescribed.

DON #101, clinical records and resident #033 confirmed that the identified medications that were ordered by the resident's physician to be administered on an identified date, at an identified time, were not administered to resident #033 as specified by the physician. [s. 131. (2)]

4. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that drugs were administered to resident #027 in accordance with the directions for use specified by the prescriber.

While inspecting CI log #007426-19 related to CIS #2931-000012-19, the following was identified:

On an identified date, RPN #139 administered an identified medication in a dosage that was not prescribed to the resident. RPN #139 reported to DON #101, and it was recorded on a Medication Incident Report.

Resident #027's clinical record, a Medication Incident Report and a conversation with DON #101 confirmed that resident #027 was not administered the medication in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683), PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2019_661683_0009
Log No. / No de registre :	030800-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 16, 2019
Licensee / Titulaire de permis :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
LTC Home / Foyer de SLD :	Idlewyld Manor 449 Sanatorium Road, HAMILTON, ON, L9C-2A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Hastings

To Idlewyld Manor, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2018_695156_0007, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s.131 (2) of Ontario Regulation 79/10.

The licensee shall prepare, submit and implement plans to ensure that resident #023, resident #033 and any other resident are administered drugs as specified by the prescriber.

Please submit the written plan for achieving compliance for inspection #2019_661683_0009 to Lisa Bos, LTC Homes Inspector, MOHLTC, by email to HamiltonSAO.moh@ontario.ca by July 30, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #001 from inspection #2018_695156_0007 issued on November 13, 2018, with a compliance date of December 31, 2018.

The licensee was ordered to:

The licensee must be compliant with s. 131(2) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that resident #001 and all other residents are administered drugs in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that resident #001, identified as resident #023 in this follow-up inspection, was administered drugs in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that an identified number of drugs resident #023's physician specified be administered were administered on an identified date.

While completing follow-up inspection log #030800-18 related to compliance order (CO) #001 from Inspection #2018_695156_0007, which ordered the licensee to ensure that resident #001 and any other residents were administered drugs in accordance with the directions for use specified by the prescriber, the following was identified:

Please note; resident #001 identified in the above noted order was identified as resident #023 in this Follow-Up inspection.

A review of resident #023's Medication Administration Record (MAR) subsequent to the above noted order compliance due date of December 31, 2018, noted that in an identified month staff had not signed to indicate that identified medications scheduled for administration at an identified time, had been administered.

During a conversation with DON #101 on an identified date, they reviewed the above noted MAR and confirmed that the medications had not been signed for as having been administered to the resident at an identified time on an identified date.

On an identified date, DON #101 provided a "Physician Order Audit Report" to Inspector #682 that confirmed the identified medications were not administered to resident #023.

DON #101, clinical documentation and the "Physician Order Audit Report" confirmed that resident #023 was not administered the identified drugs in accordance with the directions specified by their physician who prescribed the drugs. [s. 131. (2)]

2. PLEASE NOTE: The following non-compliance was identified during

concurrent inspection #2019_661683_0007 and was issued in this report.

The licensee failed to ensure that an identified number of drugs resident #033's physician specified be administered were administered on an identified date.

A review of resident #033's Medication Administration Record (MAR) indicated there was no documentation on the MAR to verify that the resident was administered identified medications at an identified time, on an identified date.

A review of clinical notes made by registered staff confirmed that there were no clinical notes made on the identified date to explain why resident #033's scheduled medications had not been administered.

In conversation with DON #101 it was verified that staff had not signed the MAR to indicate the medications scheduled had been administered at an identified time to the resident. The DON provided a "Physician's Order Audit Report" from the computerized document system which verified that all of the above noted medications were not administered.

On an identified date, a conversation was held with RPN #146 who verified they worked on an identified date, and would have been responsible for the administration of resident #033's medication, but they were unable to recall the reason the medications were not signed for on the MAR to indicate they had been administered.

During a conversation with resident #033 on an identified date, they recalled the situation where they did not receive their medications because prior to this incident there was another incident where their medications were not administered as prescribed.

DON #101, clinical records and resident #033 confirmed that the identified medications that were ordered by the resident's physician to be administered on an identified date, at an identified time, were not administered to resident #033 as specified by the physician. [s. 131. (2)]

3. PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0007 and was issued in this report.

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Resident #027's clinical record, a Medication Incident Report and a conversation with DON #101 confirmed that resident #027 was not administered the medication in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

The severity of this issue was determined to be a level 3 as there was actual risk of harm to the residents. The scope of the issues was a level 3 as it related to three of three residents reviewed. The home had a level 5 history of a re-issued compliance order to the same subsection and four or more compliance orders, that included:
-Compliance Order (CO) issued on November 13, 2018, (2018_695156_0007) (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office