Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2020	2020_555506_0020	023345-19, 012353-20, 013375-20, 016151-20	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

LESLEY EDWARDS (506)

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): August 11, 12, 13, 14, 17 and 18, 2020.

This inspection was completed concurrently with Complaint Inspection #2020_555506_0021.

The following Critical Incidents System (CIS) Inspections were conducted:
013375-20- related to falls prevention; and,
012353-20- related to falls prevention; and,
016151-20- related to falls prevention.

The following Follow-up Inspections were conducted:
023345-19- related to policy and procedures.

During the course of the inspection, the inspector(s) spoke with Senior Administrator, Administrator, Director of Nursing (DON), Registered Nurses, Resident and Family Advisor, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection the inspectors conducted tours of the home, observed resident care, reviewed clinical records, compliance plans, audits, policies and procedures, training records and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #003	2019_555506_0012	506

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was provided to the residents as specified in the plan.

A. A CIS #2931-000015-20 was submitted to the Director on an identified date in June 2020, regarding resident #003.

i. A review of the written plan of care for resident #003 identified that they were at risk for falls and had various interventions in place to try and prevent falls, which included ensuring the resident had an intervention in place at all times.

On an identified date in July 2020, resident #003 sustained a fall and the intervention was not in place. In an interview with the DON on an identified date in August 2020, it was confirmed that the expectation that the intervention was in place at all times and confirmed staff was not following resident #003's plan of care.

ii. A review of the written plan of care for resident #003 identified that the resident had an order for a treatment on an identified date in June 2020, from the physician and it was to be completed within seven days. On an identified date in July 2020, it was noted that the treatment was not completed as directed. Interview with RPN #103 confirmed that the treatment should have been removed around the end of June 2020. The DON confirmed that the plan of care was not followed.

B. A CIS #2931-000018-20 was submitted to the Director on an identified date in July 2020, regarding resident #002.

i. A review of the written plan of care for resident #002 identified that they were at risk for falls and had various interventions in place to try and prevent falls, which included an

intervention.

On identified dates in June and July 2020, the resident sustained a fall and on both occasions the intervention was not turned on An interview with RPN #108 on an identified date in August 2020, confirmed that the intervention was turned off. The RPN confirmed that this was not following the resident's plan of care as it clearly indicated that the intervention was to be on. The DON confirmed on an identified date in August 2020, that the plan of care was not followed.

C. A review of the written plan of care for resident #007 identified that they were at risk for falls and had various interventions in place to try and prevent falls, which included ensuring that the resident used a particular intervention at all times.

On identified dates in August 2020, it was documented that the resident was not wearing their fall intervention. Interview with the DON and Administrator on an identified date in August 2020, confirmed that the expectation was that the resident used the intervention at all times and the plan of care was not followed.

The home did not ensure that fall prevention strategies and treatments were implemented as per the residents' plans of care. [s. 6. (7)]

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 to ensure that the plan of care was provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #003.

The home's policy number RC-05-03-01, titled "Safe Lift Policy," last revised August 10, 2016, identified that manual lifting of total body weight of a resident without the use of a mechanical lift device was not a method to be used by the home.

Review of the clinical health record identified that resident #003 had an unwitnessed fall on an identified date in July 2020 and was manually lifted.

Following a review of the plan of care and an interview with the DON, they confirmed resident #003 was transferred with an unsafe transfer that was not to be used at the home. [s. 36.]

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 to ensure that staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 19th day of August, 2020

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

Original report signed by the inspector.