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_0021	003139-20, 004369-20	Complaint

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), JESSICA PALADINO (586)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 10, 11, 12, 13, 14, 17 and 18, 2020

This inspection was completed concurrently with Critical Incident Inspection #2020_555506_0020.

The Following Complaint Inspections were conducted:

003139-20 - related to personal support services, falls, responsive behaviours, nutrition and hydration and training; and,
004369-20 - related to nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with Senior Administrator, Administrator, Director of Nursing (DON), Registered Dietitian (RD), Recreation Therapist, Manager of Food Services, dietary aides, Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Supports Ontario (BSO), Personal Support Workers (PSW) and residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. Resident #006's current care plan included the following specific dietary interventions.

The resident was observed during the meal service on an identified date in August 2020, eating their entrée along with drinks. They were not offered a specific intervention.

The Meal Service Report did not include the specific intervention.

During interview with Dietary Aide (DA) #107, they confirmed that the resident was never offered the specific intervention and they were not aware that this was part of the care plan, as it was not on the Meal Service Report. The DA also confirmed that they offer a specific item at the meal every day, and was not aware that this was not on the care plan. Lastly, the DA confirmed that the resident preferred specific items at one meal and

another item at another meal, therefore was offered that every day at lunch.

During an interview with the Manager of Food Services (MFS), they confirmed that the care plan and Meal Service Report were inconsistent and had not been updated to reflect the current plan of care.

During an interview with the current RD #105, they acknowledged that the Meal Service Report and care plan were not consistent with each other and did not provide clear directions to staff.

Resident #006's written plan of care did not set out clear directions to staff and others who provided direct care to the resident.

B. Resident #001's written plan of care indicated that they required a specific intervention at meals, as per their preference.

A review of the Meal Service Report on an identified date in August 2020, which front line staff used to direct care, did not include the intervention for the resident. In addition, the Meal Service Report included providing a specified item at each meal; however, this was not listed in the resident's written plan of care.

In an interview with PSW #123 and DA #124, both confirmed that the resident required the specified intervention and that this should have been listed on the Meal Service Report. In an interview with the NSM, they acknowledged this and said they were well aware of the discrepancies and was working on resolving these.

Resident #001's written plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident, the resident’s substitute decision-maker (SDM), if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident’s dietary plan of care.

A. Resident #006's clinical record was reviewed and identified a progress note written by the home's former RD #109, indicated that as per the DON, the resident was no longer to have a specific intervention completed.

Progress notes were reviewed and identified that the SDM was concerned that no one had notified them that the resident had a change in condition and that no one informed them that the intervention had been discontinued.

During interviews with RD #105, Recreation Therapist #106, DON and Senior Administrator, on an identified date in August 2020, all acknowledged the above and confirmed that the resident's SDM should have been notified of the change in condition and the intervention being discontinued.

Resident #006's SDM was not given the opportunity to participate fully in the development and implementation of the resident's plan of care.

B. A complaint intake, log #003139-20, was submitted to the Director on an identified date in February 2020, by resident #001's SDM, concerned that they did not receive a phone call to their house phone when the resident was transferred to the hospital.

On an identified date in February 2020, resident #001 sustained an injury and was transferred to the hospital. According to RN #121, they acknowledged that they attempted to reach the SDM on their cell phone, but indicated that they typically only call one phone number listed.

During an interview with the DON, they acknowledged the SDM's concern and indicated that the expectation of staff was to call all numbers listed and follow up, until someone was reached, especially in situations that involved a resident being transfer to hospital. Resident #001's SDM was not given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

3. The licensee failed to ensure that the resident was reassessed and the dietary plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan was no longer necessary.

In July of 2019, resident #006 requested to no longer have a specific intervention monthly. This was added to the written plan of care. As of October 2019, monthly intervention resumed for the resident, and have remained since. The current written plan of care still indicated that the resident requested not to have the intervention completed. During an interview with RD #105, they acknowledged that this was still in the written plan of care and it had not been revised once this was no longer necessary.

Resident #006 was not reassessed and the dietary plan of care reviewed and revised when the care was no longer necessary. [s. 6. (10) (b)]

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 there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident; and that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: 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 the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: (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 were documented.

A complaint intake, log #003139-20, was submitted to the Director on an identified date in February 2020, by resident #001's SDM, concerned that the physician was not informed of a symptom the resident had been experiencing.

A progress note written on an identified date in February 2020, reported staff were to monitor for this symptom. Upon review of the resident health record, there was no information documented that the resident was monitored for this, until the SDM brought this to the physician's attention and an order written on an identified date in February 2020; nine days later.
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In an interview with the DON, they stated that it was the expectation of the licensee that the staff were to transcribe that data into each resident's Point Click Care (PCC) record, and acknowledged that this was not done for resident #001. The licensee failed to ensure that resident #001's vitals were documented. [s. 30. (2)]

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.