Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 8, 9, 10, 2011 Nov 15, 16, 17, ~~18, 25, 28, Dec 5, 2011, Jan 19, Feb 7, Mar 2, 2012.~~	2011_063165_0025	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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the director of care, the food service supervisor, the food service manager, the dietitian, registered staff, personal support workers, family members, dietary staff, the recreation manager and residents.

During the course of the inspection, the inspector(s) reviewed clinical health records, observed care, observed meal service, reviewed the homes complaint log and reviewed staff education records.
H-001797; H-001631-11; H-001638; H-001796-11; H-001661-11.

The following Inspection Protocols were used during this inspection:

Dining Observation

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. Staff members working on the Orchardview home area in 2011 were aware that an identified resident had a bowel movement prior to being assisted to the dining room for the evening meal however, staff failed to provide the resident with care and assistance until the resident was changed one hour and thirty-five minutes later. The plan of care identified that the resident was at risk to develop ulceration or interference with structural integrity of layers of skin caused by prolonged pressure related to incontinence.

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 every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
An identified resident's plan of care indicated for staff to provide 2x 250ml fluid at meals and snacks however, November 8, 2011 during the lunch meal the resident only received 1x 250ml orange juice.
An identified resident's plan of care indicated for staff to offer fruit for dessert first before offering other types however November 9, 2011 during the lunch meal, the resident was offered both fruit and cake at the same time resulting in the resident choosing cake. The resident is diabetic.
An identified resident received nectar thickened orange juice November 10, 2011 however, the dietary kardex indicated that the resident was to receive honey thickened fluids. The dietary aide interviewed indicated the home does not have honey consistency fluids.
November 8, 2011 an identified resident had gingerale and muffin for the pm nourishment, November 16, 2011 the resident had gingerale and 1/2 a sandwich on the bedside table for pm nourishment however the resident's plan of care related to diabetes indicated the resident was to receive 1 muffin, 1 banana and 125 ml lactaid milk for pm nourishment.
An identified resident did not receive ensure plus and a magic cup during the lunch meal November 8, 2011. The physician order and plan of care indicated the resident was to receive 237ml of ensure plus at 12:00 however, the registered practical nurse confirmed that the resident was not provided the supplements as ordered.
An identified resident did not receive a magic cup during the lunch meal November 8, 2011. The resident's medication administration record indicated the resident was to receive a magic cup at 12:00 however, the registered practical nurse confirmed that the resident was not provided the supplement as ordered. Interviews with registered staff, dietary staff and the nutrition manager confirmed that there was no system in place to ensure that residents were receiving magic cups as prescribed.
An identified resident did not receive 115ml glucerna during the lunch meal November 8, 2011. The resident's medication administration record indicated the resident was to receive 115ml glucerna at 12:00 however, the registered practical nurse confirmed that the supplement was not provided to the resident as ordered. The RPN confirmed that she did not have glucerna supplements available on her home area to provide the resident at the time of her 12:00 medication pass.
An identified resident's kardex indicated that the resident was to receive two handled mug for beverages however, the resident only received a two handled mug for juice and received milk in a regular glass.
An identified resident's kardex indicated that the resident was to receive cups with lids however the resident received one glass of orange juice in a regular glass with no lid during the lunch meal November 8, 2011.
An identified resident's kardex indicated that the resident was to receive yogurt however, the resident did not receive yogurt during the lunch meal November 8, 2011.
An identified resident's kardex indicated that the resident was to receive pudding thickened fluids however, the resident received one glass of nectar consistency juice and another identified resident's kardex indicated that they were to receive honey thickened fluids however, they received one glass of nectar thickened orange juice during the lunch meal November 8, 2011.
Dietary staff and the nutrition manager confirmed that the home only purchased nectar thickened fluid however, nutrition manager stated that the expectation was that staff thickened fluids using a thickening agent to the appropriate consistency for honey and pudding thickened fluids.
2. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. The plan of care for an identified resident indicated for staff to provide ground texture with puree soup nectar thickened fluids. The plan of care related to nutrition status and diet only indicated ground texture with puree soup, and the plan of care related to eating indicated ground texture with puree soup on good days and puree texture on bad days and nectar consistency thickened fluids. The physicians medication order review indicated moist, minced texture solids and nectar fluids on good days, pureed solids and nectar fluids on bad days.
An identified resident's printed nutritional plan of care for staff indicated for staff to provide a ground texture however, the physician's order signed by the dietitian, the computerized plan of care and the dietary kardex indicated the resident was to receive a ground texture at breakfast and supper and a puree texture at the lunch meal.
An identified resident's printed nutritional plan of care for staff and the dietary kardex indicated the resident was to receive a puree diet with nectar thickened fluids however, the physicians order written by the dietitian indicated puree texture, nectar thickened fluids with exceptions. RN/RPN may give ground or thin fluids as tolerated.

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 is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: abuse recognition and prevention.
Resident abuse training was originally scheduled for March 2011 however, this was not completed by the home. A memo with the zero tolerance of abuse and neglect policy and mandatory and critical incident reporting policy were sent to registered staff August 30, 2011 however, only fourteen registered practical nurses and eight registered nurses signed off on reading and understanding the homes policies. Personal support workers and other staff who provide direct care to residents had not received the memo or policy provided to registered staff at the time of the inspection. Previous abuse training for all staff occurred June 25, 2010 however, only four staff members and three members of management attended the training.

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following subsections:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the planned menu items are offered and available at each meal and snack.
The planned menu for the lunch meal November 8, 2011 indicated minced apricots however, they were not available and offered to residents in the Orchardview dining room and minced peaches were served in it's place. The therapeutic menu indicated ground red roasted potatoes however the dietary staff confirmed they were not available to residents and mashed potatoes were offered in it's place. The therapeutic menu indicated fish with lemon however, there was no lemon available and offered to residents.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home has a dining and snack service that included, providing residents with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
An identified resident received a regular glass with a straw November 8, 2011 and November 16, 2011 at the pm nourishment pass however, the plan of care for restorative eating program and potential for dehydration indicated that 2 handled mugs for fluids are to be provided for the resident. November 16, 2011 the resident was observed in their room trying to reach the glass of gingerale on the bedside table when the inspector arrived. The resident's beverage and sandwich were placed out of reach for the resident. The resident indicated that they were unable to reach the beverage and stated that they would like to have a drink. The inspector had to assist the resident as it was placed out of reach. The personal support worker indicated the resident was sleeping when nourishments were passed.
An identified resident received 1 cranberry juice in a 2 handled cup and 1 glass of milk in a regular glass during the lunch meal November 8, 2011 however, the resident's dietary kardex indicated for staff to provide 2 handled cups for fluids to maintain independence.
An identified resident received 1 cup of orange juice (in a regular glass) during the lunch meal November 8, 2011 however, the dietary kardex and the resident's plan of care for nutrition status indicated for staff to provide fluids in a cup with lids to maintain the resident's independence.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
A family member of a resident called the director of care stating that the resident indicated to family that staff were restraining the resident at night and the family was worried that the resident was being mistreated. The director of care documented in the resident's clinical record that an investigation would be initiated related to the allegations including restraint use and staffing. A review of the resident's clinical record indicated the family had previously brought the same concerns forward to the director of care twice prior however; the director of care confirmed no formal investigation was completed that included any documented outcomes, a resolution to the complaint and a response to the complainant once the investigation was completed.

A response letter was completed by the home after receiving a complaint letter from a family member in 2011. The response letter however did not address concerns the resident had with a staff member. The director of care confirmed that the home failed to initiate and conduct and investigation when the correct identity of the staff member was provided to the home by family.

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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee of the home did not ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
The point of care report and the resident bath log indicated that a resident only received one bath per week. There was no indication in the resident's clinical record that a second bath was provided. Registered staff and personal support workers confirmed that when baths are completed they are recorded in point of care and the resident bath log.

Issued on this 6th day of March, 2012

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