Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 15, 18, 19, 20, 2011	2011-165-2931-14Apr1111951	Complaint H-000807-11 H-00532

Licensee/Titulaire
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(s)

Tammy Szymanowski

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the administrator, director of care, director of program development, residents, family members, registered staff, and personal support workers.

During the course of the inspection, the inspector: observed meal service, reviewed clinical health records, reviewed policy and procedures.

The following Inspection Protocols were used during this inspection: nutrition and hydration inspection protocol and reporting and complaints inspection protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 vpc

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s3(1)11.i Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: Every resident has the right to, participate fully in the development, implementation, review and revision of his or her plan of care.

Findings:

The resident's did not have an opportunity to participate fully in the development, implementation, review and revision of his or her plan of care. Several residents in Orchardview dining room were moved from their original seating plan without notification and an opportunity to participate in the implementation of the move.

1. An identified resident stated that they were not happy with there recent table change and they objected to the change. The resident indicated that they did not know about the move prior to the move occurring and it came as a surprise.
2. One identified resident stated that they are not pleased with the recent table changes, they liked where they were previously sitting and indicated that they felt like they are always in the way in their new spot. The resident indicated that the home did not notify or discuss with them prior to the change and the move came as a surprise.
3. An identified resident indicated that they were not happy with the recent seating changes made and indicated that they and their family member were notified of the seating changes prior to implementation.
4. The substitute decision makers for identified residents confirmed they were not notified of the residents seating changes prior to implementation and family indicated to the home that they did not feel it was in the best interest for the resident.
5. Registered staff and management of the home confirmed that they did not involve the resident or substitute decision makers in the development and implementation of the seating changes.

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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, the home shall ensure that the following rights of residents are fully respected and promoted and every resident has the right to, participate fully in the development, implementation, review and revision of his or her plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s6(1)(c) Every licensee of a long-term care home shall 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. 2007, c. 8, s. 6 (1).

Findings:

1. An identified resident's plan of care did not provide clear direction for staff providing care. The nutritional plan of care indicated that the resident requires a regular textured diet, soft texture however; the eating plan of care indicated that the resident requires a puree texture.
2. The plan of care indicated for staff to monitor symptoms of choking however; it did not set out clear direction including strategies for staff to manage the risk for choking.

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WN #3: The Licensee has failed to comply with the LTC Homes Act, 2007, S.O.2007, c.8, s6(4)(a) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Findings:

1. An identified resident's clinical record indicated that the resident had a choking incident in 2011 however; there was no collaboration with nursing and dietary in the assessment of the resident in relation to identified difficulties. There was no referral to the dietitian for an assessment and follow up.
2. The director of care indicated that the expectation of the home is to initiate a dietitian referral when a choking incident occurs.
3. Policy RC-04--1-12 indicated that if a resident is coughing or choking on liquids or solids a referral to the dietitian should be initiated by nursing so that a dietitian assessment can be completed.

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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Feb 7/2012