Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 15, 2013	2013_240506_0001	H-000501-13, H-000379-13	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), MARILYN TONE (167)

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): October 1,3,4 and 7, 2013

This inspection was completed related to critical incidents log # H-000501-13, H-000379-13 and H-000301-13.

Area of non-compliance LTCHA s. 6(10)b will also be issued on this report related to inspection # 2013_201167_0028/H-000277-13 conducted simultaneously with this inspection.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Nursing Staff, the Resident Assessment Instrument Co-ordinator (RAI Co-ordinator), Director of Care (DOC), Director of Finance and identified residents.

During the course of the inspection, the inspector(s) conducted a review of the health files for identified residents, reviewed relevant policies and procedures, observed resident care and reviewed notes related to investigations completed by the home.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

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 written plans of care for resident's # 002, # 003 and # 004 were not reviewed and revised when their care needs changed.

A) During an observation of resident # 002 on an identified date, it was noted that the resident was tilted in a reclined position using a tilt wheelchair for positioning and comfort. There is no mention in the resident's care plan that the resident was to be tilted in their wheelchair to assist in positioning and comfort. During an interview with a PSW they confirmed that when the resident is up, their wheelchair is to be tilted for comfort measures. The registered staff on the unit confirmed that they do not routinely add to the care plan that a resident needs to be tilted in their wheelchair for positioning and comfort.

B) The document that the home refers to as the care plan that directs staff to provide care did not identify specific behaviours that the resident had been demonstrating. Identified triggers that precipitated these behaviours were not identified nor were there interventions developed to manage the behaviours.

- During an interview with a PSW, it was confirmed that staff were aware of strategies related to the management of resident # 003's behaviours. When asked if new staff members were working how they would know what interventions would work in reducing heightened behaviours the PSW indicated that most of the time someone knows. PSW also indicated two staff were required to provide a shower to the resident, however there was no mention of this in the resident's care plan. This information was confirmed by record review and the Director of Care.

C) Resident # 004 was noted to have had a fall on an identified date that resulted in an injury and transfer to hospital. The resident returned to the home and fell again and sustained a second injury resulting in transfer to hospital.

The resident developed complications related to the injuries.

- During a review of the progress notes for the resident, it was noted that the resident 's pain increased after each injury, their level of mobility changed and abilities related to transferring, some new behaviours were identified, and the resident required the use of specified medical equipment and special directions related to their care to prevent injury.
- During a review of the document that staff refers to as the care plan, that was confirmed by the RAI Co-ordinator to be the most current care plan available for resident # 004, it was noted that the care plan was not reviewed and revised to include the information that was identified in the progress notes related to the resident's newly identified care needs.
- The resident 's condition continued to deteriorate but no palliative care plan was in

place to address the resident's palliative needs prior to their death.
- It was noted that the documentation in the progress notes confirmed that appropriate care was provided to the resident but the required care was not included in the care plan. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:

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. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Resident # 002 and # 005 were not treated with courtesy and respect and in a way that respected their dignity.
- On an identifed date, resident # 002 was in their room with two staff members getting ready to use a mechanical lift for care. The two staff members proceeded to have an altercation with each other in front of the resident.
- On an identified date, a PSW was seated at a dining room table during the lunch meal with resident # 005. While seated at the dining room table the PSW was not conversing with the resident but was involved in a personal conversation.[s. 3. (1) 1.]

2. Resident # 007's privacy was not respected when a treatment was provided to the resident in a common area.
- On an identified date, during a tour of a resident home area, it was observed that a registered staff was changing a resident's dressing in a common area with a number of other residents present and in close proximity. [s. 3. (1) 8.]

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 residents are treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity and that all residents are afforded privacy when treatment is provided., to be implemented voluntarily.

Issued on this 25th day of November, 2013

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

Lesley Edwards / Marilyn Lore

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), MARILYN TONE (167)
Inspection No. / No de l'inspection :	2013_240506_0001
Log No. / Registre no:	H-000501-13, H-000379-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 15, 2013
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 :	MAUREEN GOODRAM

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

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

Ministére de la Santé et des Soins de longue durée

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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that when residents' care needs change or when the care set out in their plans of care are no longer necessary, that the plan of care is reviewed and revised to reflect the resident's current status.

The plan shall be submitted electronically to Lesley Edwards at Lesley.Edwards@ontario.ca by October 25, 2013.

Grounds / Motifs :

1. The written plans of care for resident's # 002, # 003 and # 004 were not reviewed and revised when their care needs changed.

A) During an observation of resident # 002 on an identified date, it was noted that the resident was tilted in a reclined position using a tilt wheelchair for positioning and comfort. Staff interviewed confirmed that the resident requires the use of a tilt wheelchair for comfort and positioning. The document that the home refers to as the care plan was not updated to include that the resident is to be tilted in the wheelchair.
B) Resident # 003 had been experiencing new responsive behaviours. The care plan did not include identification of these behaviours. Triggers that precipitated these behaviours were not identified nor were there interventions developed to manage the behaviours.
C) Resident # 004 sustained falls that resulted in injury and transfer to hospital. Upon the resident's return from hospital, it was noted that the document that the home refers to as the care plan was not updated to include the changes in the resident's condition or interventions in place to manage the changes. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 08, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of October, 2013

Signature of Inspector / Signature de l'inspecteur : Lesley Edwards

Name of Inspector / Nom de l'inspecteur : Lesley Edwards

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