Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 19, 2023	
Inspection Number: 2023-1415-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Idlewyld Manor	
Long Term Care Home and City: Idlewyld Manor, Hamilton	
Lead Inspector Emmy Hartmann (748)	**Inspector Digital Signature**
Additional Inspector(s) Lesley Edwards (506)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24,-26, 29-31, 2023, and June 1, 2023.

The following intake(s) were inspected:
- Intake #00020132 was for a Proactive Compliance Inspection (PCI) for the home.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 5

The licensee has failed to ensure that the long-term care home (LTCH) was a safe and secure environment for its residents.

Rationale and Summary
The LTCH Inspector observed several tools unattended in a resident home area. Upon speaking with staff, they acknowledged that the home had contractors in, who were working on flooring and acknowledged that they should not have left the tools out as they were not in the home at the time of the observation.

The maintenance staff removed the tools immediately to ensure that the residents were kept safe and secure.

Sources: Observation of the area; staff interviews.
[506]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident related to bathing.

Rationale and Summary
The resident's care plan identified that they received their bathing on Wednesdays and Saturdays. However, a printed bath list identified that it was completed on Tuesdays and Fridays.

The DOC identified that the care plan was not revised when the bathing days changed and corrected the

information.

Sources: Review of care plan, and printed bath list; interview with DOC.
[748]

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (2)

The licensee has failed to ensure that the doors leading to a balcony that was secured, were locked.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Specifically, the home failed to comply with the policy “Doors Leading to Outside Secured Areas,” last revised July 10, 2023.

During a tour of the home, Inspector #506 observed that a door leading to a balcony that was enclosed in a resident home area, second floor, was not locked. The home’s policy identified that all balcony doors should be locked unless residents were being supervised on the balcony.

The home immediately rectified this and locked the doors.

Sources: Observations; home’s policy “Doors in the home” (last revised January 10, 2023); Interview with Associate Director and other staff.
[506]

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 281 (1) 1.

The licensee has failed to ensure that records of current staff members were kept at the home.

Rationale and Summary
During a request of current staff member records, the DOC identified that records were not kept at the home.

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The records were moved back to the home.

Sources: Interview with DOC.
[748]

WRITTEN NOTIFICATION: Menu planning

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary
During a meal observation in a resident home area, the planned menu item for lunch was hamburgers and sweet potato fries. It was observed that residents that received modified texture diets were given mashed potatoes instead of sweet potato fries. The Dietary Aide (DA) acknowledged that they did not have sweet potato fries for residents on a modified texture diet.

The Food Service Manager (FSM) acknowledged that if an item was listed on the menu, it should be offered and available to all residents.

Not having planned menu items available for all diet textures prevented residents from having their choice at the meal service.

Sources: Meal observation; Interview with DA and other staff.
[506]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC), was implemented.

Rationale and Summary
According to the IPAC Standard, the licensee was to ensure that Routine Practices and Additional

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Precautions were followed in the IPAC program; and at minimum Routine Practices was to include the proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

A resident room was observed to be on additional precautions. Interview with a PSW identified that staff were required to apply PPE when providing care to the resident, and doff PPE at the door. They acknowledged that there was no surgical mask available by the resident's door.

The IPAC lead and DOC identified that they expected staff to don and doff their mask at point of care.

There may have been an increased risk of transmission of disease when there was no surgical masks available at point of care.

Sources: Observation; interviews with PSW, IPAC lead and DOC.
[748]

WRITTEN NOTIFICATION: Orientation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included, signs and symptoms of infectious diseases.

Rationale and Summary
The home's current training materials for infection prevention and control (IPAC) for orientation of new staff, did not include signs and symptoms of infectious diseases.

The IPAC lead verified that the training materials used did not include signs and symptoms of infectious diseases.

Staff may not be able to respond timely to infectious diseases if training on the signs and symptoms were not included in their orientation.

Sources: Review of training materials for orientation of new staff; interview with IPAC lead.

[748]