Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: April 9, 2024
Inspection Number: 2024-1415-0001
Inspection Type: Complaint Critical Incident
Licensee: Idlewyld Manor
Long Term Care Home and City: Idlewyld Manor, Hamilton

Lead Inspector	**Inspector Digital Signature**
Lisa Vink (168)	Lisa Vink Digitally signed by Lisa Vink Date: 2024.04.09 15:48:40 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 3 and 4, 2024, and offsite on April 5 and 8, 2024.

The following intakes were inspected:

- Intake: #00107129 related to duty to protect.
- Intake: #00110197 related to duty to protect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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)
Non-compliance with: FLTCA, 2021, s. 25 (2) (b)
Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(b) shall clearly set out what constitutes abuse and neglect;

The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constituted sexual abuse.

Rationale and Summary
The home's Non Abuse of Residents policy provided definitions of sexual abuse as set out in O. Reg 246/22; however, also included what was not considered sexual abuse in their definition of abuse, specifically: "(a) touching, behaviour or remarks of a clinical nature that were appropriate to the provision of care or assisting a resident with activities of daily living; or
(b) consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that was in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member."

The policy was revised on April 8, 2024, to clearly set out what constituted sexual abuse and what was not considered sexual abuse.

Sources: Review of Non Abuse of Residents (IWD) policy, number B 12.0, version July 21, 2023 and April 8, 2024, and interviews with staff. [168]

Date Remedy Implemented: April 8, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that the right of a resident to proper care and services consistent with their needs were fully respected and promoted.

Rationale and Summary
A resident was admitted to the home and was scheduled for a specific activity of daily living a few days later.
Staff provided care to the resident; however, did not provide care consistent with their needs when they performed all aspects of the task and failed to ensure that the resident was fully aware of the procedure.
According to the resident they agreed to the activity of daily of living and was able

to participate, in part, with set up assistance.
Staff reported that they did inform the resident prior to a specific aspect of the care; however, there was an external noise in the room and maybe it was hard to hear.
The resident reported that staff did not explain the care and they were upset by their actions.
The day following the resident reported concerns related to the care they received.
Failure to ensure the resident's right to proper care and services consistent with their needs resulted in emotional distress.

Sources: Review of plan of care of the resident, review of investigative notes and statements, review of video footage prior to and following the provision of care, reveiw of licensee's Non Abuse of Residents policy and interviews with the resident, a person of importance and staff. [168]

WRITTEN NOTIFICATION: 24 Hour Admission Care Plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (6)
24-hour admission care plan
s. 27 (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 246/22, s. 27 (6).

The licensee has failed to ensure that the care set out in the care plan was provided to a resident as specified in the plan related to transfers and a specific activity of daily living.

Rationale and Summary
The care plan identified that a resident required a specified level of staff assistance for transferring and a specific activity of daily living.
Staff transferred and provided the specified activity of daily living with a level of

assistance which was not consistent with the plan.
There was a risk of injury to the resident when care was not provided at the level of assistance as specified in the plan.

Sources: Review of care plan for a resident and interviews with the resident and staff. [168]