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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Public Report

Report Issue Date: August 11, 2025
Inspection Number: 2025-1415-0003
Inspection Type: Critical Incident
Licensee: Idlewyld Manor
Long Term Care Home and City: Idlewyld Manor, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6, 7, 8, 11, 2025

The following intake(s) were inspected:
-Intake: #00152651 - Critical Incident (CI) 2931-000014-25 - Infection prevention and control.
-Intake: #00153172 - CI 2931-000015-25 - Prevention abuse and Neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs stored in a medication cart was secured and locked on a set date. This observation was acknowledged by two Staff members.

One staff noticed that another staff left the cart and the screen unlocked and was standing in the dining room. The staff went and locked the cart and the computer screen immediately during the observation.

Date Remedy Implemented: August 6, 2025

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies were developed and implemented for a resident relating to their responsive behaviours towards another resident.

On a set date, two residents engaged in a physical altercation. The admission assessment, and the progress notes indicated that one of the residents demonstrated potential responsive behaviour towards another resident.

The home's management acknowledged that there had been no strategies identified or implemented to manage behaviours prior to the incident.

Sources: residents plan of care and clinical records, and interview with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

Section 6.1, of the IPAC Standard, specified that the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and

ensuring adequate access to PPE for Routine Practices and Additional Precautions.

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was upheld when there were no gowns in two isolation carts at the point of care for contact isolation rooms on a set date.

Sources: Observation, PPE policy, Interview with staff.