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

Original Public Report

Report Issue Date: September 3, 2024	
Inspection Number: 2024-1415-0002	
Inspection Type: Critical Incident	
Licensee: Idlewyld Manor	
Long Term Care Home and City: Idlewyld Manor, Hamilton	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date (s): August 26, 27, 28, 2024

The following intake (s) were inspected:

- Intake: #00114338 – [Critical Incident (CI): 2931-000005-24] related to Infection Prevention and Control.
- Intake: #00115478 – [CI: 2931-000006-24] related to Infection Prevention and Control.
- Intake: #00117500 – [CI: 2931-000007-24] related to Infection Prevention and Control.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC) was followed.

Rationale and Summary
As outlined in the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 9.1 (b) states at minimum Routine Practices shall include, hand hygiene, including, but not limited to, at the four moments of hand hygiene, before initial resident/resident environment contact. Section 9.1 (e) also states at minimum Routine Practices shall include Use of controls, including environmental controls, including but not limited to location/placements of residents' equipment, cleaning, making hand hygiene products available.

On a specified date, a staff was observed assisting a resident without removing the gloves that they were wearing to perform their duties. Neither did they perform hand hygiene prior to supporting the resident. A day later, another staff was observed transitioning between different tasks using the same gloves. They did not perform hand hygiene.

Sources: Observations, and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed when an outbreak was declared in the home by the local Public Health Unit.

Rationale and Summary
An outbreak was declared in the home on a specified date. Upon receiving confirmation from the local Public Health Unit, the home did not inform the Director immediately.

Sources: Critical Incident Report, and interview with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer was followed by the home, in relation to alcohol-based hand rub (ABHR).

Rationale and Summary
On three different dates, two bottles of alcohol-based hand rub with expired ABHR products were observed in two different home areas.

Prior to exiting the home, the expired products were still in the same locations that they were originally seen.

Sources: Observations, ABHR labels, and interview with staff.