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: November 7, 2024	
Inspection Number: 2024-1415-0003	
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): October 29-31, 2024, November 1, 2024, and November 4, 2024

The following intake(s) were inspected:

- Intake #00123703 - related to falls prevention and management.
- Intake #00125583 - related to falls prevention and management.

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

Infection Prevention and Control
Residents' Rights and Choices
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)
Non-compliance with: O. Reg. 246/22, s. 351 (2) 1.
Protection of privacy in reports
s. 351 (2) Where an inspection report mentioned in clause (1) (a), (c) or (d) contains personal information or personal health information, only the following shall be posted, given or published, as the case may be:
1. Where there is a finding of non-compliance, a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting the finding.

The licensee has failed to ensure that when an inspection report contains personal information or personal health information, only a version of the report that has been edited by an inspector so as to provide only the finding and a summary of the evidence supporting finding is posted.

Rationale and Summary
On a specified date, a Licensee Report for a previous inspection was observed to be publicly posted in the home.

The Administrator confirmed the Licensee Report had been posted in the home

erroneously and stated the Public Report would be posted in its place.

Later on the same specified day, a Public Report for the previous inspection was observed to be posted in place of the Licensee Report.

Sources: Observation of the posted Licensee Report and interviews with Administrator.

Date Remedy Implemented: October 31, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that clear directions related to a resident's bed mobility/transfer status was provided to staff.

Rationale and Summary
On an identified date, an observation was made of a resident's room during which a specific bed mobility/transfer logo was found near the door of the room.

A review of the resident's care plan indicated that the level of bed mobility assistance the resident required was not what was depicted in the logo.

A registered staff member acknowledged that the transfer logo was not updated as per the resident's current care need level.

Failure to ensure that the resident's bed mobility/transfer logo was up-to-date may have resulted in the resident not receiving the required level of assistance during transfers based on their transfer level needs and current care plan.

Sources: Observation; resident's care plan; interview with registered staff.

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management policy to identify pain for a resident post-fall on a specified date was complied with.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the Pain Management Program policy of the long-term care home is to be complied with.

Specifically, the staff did not comply with the Pain Management Program Policy of the long-term care home on ensuring that a pain assessment was completed for a resident with the onset of a new pain post-fall on a specified date.

Rationale and Summary

A resident sustained a fall on a specified date. A review of progress notes from the day of incident indicated that the resident was expressing pain in their limb. During the review of the resident's clinical record, no pain assessment was found from the day of incident when the resident complained of a new onset of pain.

The long-term care home's 'Pain Management Program Policy' (section 8.0) outlined the responsibility of the registered staff to follow up on the reported pain by assessing the resident using either numerical score of pain for residents who are cognitively well or Pain Assessment in Advanced Dementia (PAINAD) for residents who are cognitively impaired.

A registered staff reviewed the resident's record and acknowledged that a pain assessment was not completed when the resident complained of a new onset of pain. The registered staff acknowledged this should have been documented using a clinically appropriate pain assessment instrument as outlined in the LTCH's pain management policy.

Failure to comply with the licensee's written policy on pain management on ensuring that a clinically appropriate pain assessment instrument was completed for the resident with the new onset of pain, resulted in failure to assess and identify the presence of pain.

Sources: Pain Management Program Policy (Section 8.0, Last Reviewed: November 2023); resident's records; interview with registered staff.

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the Fall Prevention and Management Program policy of the long-term care home is to be complied with.

Specifically, the staff did not comply with the Falls Prevention and Management Program Policy of the LTCH on ensuring that a Head Injury Routine (HIR) assessment was initiated and completed post-fall for a resident on a specified date.

Rationale and Summary

During a review of a resident's record, no HIR assessments was found for a resident's post-fall on a specified date.

The long-term care home's 'Falls Prevention and Management Program Policy' (section 9.0) outlined the responsibility of the registered staff to initiate a HIR assessment after a fall that results in a significant change in condition.

A registered staff reported that either 'Neurological Flow Sheet' stored in the

resident's chart or in the home's electronic records system is used to document HIRs for residents post-fall. The registered staff reviewed the resident's chart and electronic system records post-fall for the specified date and confirmed that HIR documentation was not found as it was not completed post-fall.

Failure to ensure that the resident was assessed post-fall using a clinically appropriate assessment instrument increases the risk of not being able to identify any injuries that may have a significant impact on the resident's health and well-being.

Sources: Falls Prevention and Management Program Policy (Section 9.0, Last Reviewed: June 2023), resident's records, interview with registered staff.