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

Public Report

Report Issue Date: January 28, 2025
Inspection Number: 2025-1415-0001
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): January 23-24, and 27-28, 2025.

The following intake(s) were inspected:

- Intake: #00129297 - Critical incident (CI): 2931-000012-24 - related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

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,
(a) the planned care for the resident;

The licensee failed to ensure that the written plan of care for a resident set out the planned care for the resident with regard to the resident's sleep preferences. Staff confirmed the resident preferred to sleep in a location other than their bed and would frequently sleep there.

Sources: Interviews with staff and resident's care plan.

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 the written plan of care for a resident provided clear directions to staff related to falls prevention interventions. A falls prevention intervention was not in place at the time of a resident fall. Staff believed the intervention was required at a time not specified in the care plan.

Sources: Resident's care plan, interviews with staff and DOC.

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