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: March 27, 2026
Inspection Number: 2026-1415-0004
Inspection Type: Critical Incident Follow up
Licensee: Idlewyld Manor
Long Term Care Home and City: Idlewyld Manor, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 12, 13, 16, 18, 19, 23, 24, 25, 26, 27, 2026

The following intake(s) were inspected:
-Intake: #00165430 - Follow-up #01 - CO #001/2025-1415-0004 - Emergency Plans.
-Intake: #00167840 - 2931-000001-26 - Responsive behaviors.
-Intake: #00167997 - 2931-000002-26 - Resident care and support services.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1415-0004 related to O. Reg. 246/22, s. 268 (4) 1. vi. inspected.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The care set out in the plan of care for a resident was not provided as specified in the plan when staff did not follow the order in place and carried out resident's treatment without obtaining a new doctor’s order.

Sources: Observation, critical incident (CI), investigation notes, interview with staff.

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) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

Resident's plan of care specified that documentation for an observation was to be completed on two separate occasions for five and seven days, respectively. On multiple days, documentation was not completed for four or more hours.

Sources: resident's clinical records; and interviews with staff.