Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 13, 2022
Inspection Number # 2022-1394-0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Halton Healthcare LTC Inc.

Long-Term Care Home and City
Wyndham Manor Long Term Care Centre, Oakville

Lead Inspector
Barbara Grohmann (720920)

Inspector Digital Signature
Barbara Grohmann
2022.05.16 08:53:27 -04'00'

Additional Inspector(s)
Inspector #632 (Yuliya Fedotova) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 28-29, May 2-3, 5-6 and 9, 2022.

The following intake was inspected:

- Log # 006456-21 (CIS # 2910-00005-21) related to falls prevention and management.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

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INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s. 6 (10)(b)*

The licensee has failed to ensure that the plan of care was revised when a resident had changes in their care needs post fall and recovery.

Rationale and Summary

A resident had a fall, was transferred to hospital, and experienced a change in their condition. As a result, they were unable to walk independently and required the temporary use of a mobility device.

i. After the resident returned from the hospital their care plan stated that the resident used a mobility device on/off the unit and required total assistance. However, another part of the care plan indicated that the resident walked independently with supervision.

ii. At the time of the inspection, the Kardex and task list indicated that the resident required total assistance with their mobility device for locomotion on the unit and locomotion off the unit. However, the care plan stated that the resident could walk without assistive devices.

The resident was observed walking in the dining room without any mobility devices. Staff stated that the resident used a mobility device for a short time and currently walked independently. The DOC confirmed that the Kardex was part of a resident's plan of care and expected it to match the care plan. The DOC stated that the care plan should be revised when a resident's care needs change.

Failure to revise the plan of care had the potential for the resident not to receive care in accordance with their needs.

Sources: resident's clinical records; observations; interviews with the DOC and other staff. [720920]