Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 16, 2021	2021_729615_0003	022785-20	Complaint

Licensee/Titulaire de permis

Halton Healthcare LTC Inc.
327 Reynolds Street Oakville ON L6J 3L7

Long-Term Care Home/Foyer de soins de longue durée

Wyndham Manor Long Term Care Centre
291 Reynolds Street Oakville ON L6J 3L5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 1, 2, 8 and 9, 2021.

The following intake was inspected during this inspection:

Log #022785-20, Complaint related to staffing, personal support services, nutrition and hydration and infection prevention and control.

This inspection was concurrently inspected with Inspection 2021_729615_0004 which included staffing and infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care-Infection Prevention and Control Lead, the Maintenance/Housekeeping Manager, the Office Manager, two Charge Nurses, one Registered Practical Nurse, one Personal Support Worker and one Disinfectant Staff.

The inspector(s) also toured the home, interviewed staff, observed residents and care provided to them, reviewed clinical records and other relevant documents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of a resident's nutritional status and any risks related to nutrition care.

A review of the Registered Dietitian's progress notes and assessments on three different dates identified that a resident had risks related to nutrition and nutritional preferences. Nowhere in the resident's care plan or plan of care this information was shared with staff. During interviews with a Registered Practical Nurse and a Personal Support Worker both stated that they were unaware of this information. During observations of a Dietary Aid plating residents meals, they could not identify on a residents' list that the resident had risks related to nutrition and nutritional preferences. During an interview with the Director of Care, they stated that the expectation was that the resident's nutritional information be shared with staff and be included in the resident's plan of care.

The home's failure to not include the resident's nutritional status and any risks related to nutrition care posed a risk of harm to the resident's health status.

Sources: resident's clinical records, Registered Dietitian's notes and assessments, observations and interviews with staff. [s. 26. (3) 13.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment of residents' nutritional status and any risks related to nutrition care, to be implemented voluntarily.

Issued on this 18th day of February, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.