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

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Original Public Report

Report Issue Date: April 6, 2023	
Inspection Number: 2023-1394-0002	
Inspection Type: Complaint Critical Incident System	
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 2023.04.11 14:23:37 -04'00'
Additional Inspector(s) Klarizze Rozal (740765)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 1-3, 6-10, 13-16, 20 and 22, 2023.

The following intakes were inspected in this complaint inspection:

- Intake: #00004006 was related to personal care, housekeeping and staffing.
- Intake: #00004526 was related to staffing, housekeeping, cleanliness of dishware, personal care, air temperatures and programs.
- Intake: #00004850 was related to hand hygiene, and cleanliness of dishware.
- Intake: #00016698 was related to skin and wound, personal care, weight change and nutrition interventions.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00002638 [CI: 2910-000006-22] was related to unknown incident resulting in hospitalization.
- Intake: #00003182 [CI: 2910-000008-21] was related to alleged emotional abuse.
- Intake: #00003699 [CI: 2910-000006-21] was related to alleged improper care.
- Intake: #00007785 [CI: 2910-000012-22] was related to alleged physical abuse.
- Intake: #00018778 [CI: 2910-000002-23] was related to falls prevention and management.

The following intakes were completed in this inspection: intake #00002012, CI 2910-000014-21; intake #00002753, CI 2910-000011-21; intake #00003075, CI 2910-000009-21; intake #00003865, CI 2910-000012-21; intake #00006394, CI 2910-000007-22; intake #00006414, CI 2910-000009-22; intake #00011328, CI 2910-000015-22; and intake #00018320, CI 2910-000001-23 were related to falls prevention and management.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Recreational and Social Activities
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)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's written plan of care related to bathing set out clear directions for staff and others who provide direct care to the resident.

Rationale and Summary
Upon review of a resident's written care plan, two different bathing schedules were documented, indicating baths would be performed on different days and at different times of day.

The registered nurse stated that the resident had a recent change to their bathing schedule. They acknowledged the care plan had two different bathing schedules and needed to be edited. The nurse corrected the written care plan in accordance with the latest bathing schedule, updated and signed by the DOC.

Sources: resident's clinical records, bathing schedule, and interview with staff.

Date Remedy Implemented: March 13, 2023 [740765]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care for a resident was revised when their care needs changed, specifically related to body mass index (BMI) and goal weight range.

Rationale and Summary
A resident's admission height was recorded and resulted in a BMI over 30. The Registered Dietitian (RD) created a goal weight range for the resident which would result in a BMI range between 22 and 27. The resident's care plan was created after their admission and documented both their BMI and goal weight range.

When the home took the resident's annual height, staff recorded an increase compared with their measured height on admission. The updated height resulted in a lower BMI.

After the change in height, progress notes from the RD stated that the resident's current BMI was ideal; however, no change to the resident's care plan regarding their BMI and/or goal weight range was done. Based on the resident's current height, their goal weight range as indicated in their care plan would result in a BMI below 18.5.

The Canadian Guidelines for Body Weight Classification in Adult from Health Canada documented that a BMI under 18.5 has an increased risk of developing health problems and that for adults over the age of 65, a normal BMI range may begin above 18.5 and extend beyond 24.9.

The Director of Care (DOC) acknowledged that they expected a resident's care plan, including goals, be updated when anything changes the resident's care needs, including a change in height.

Failure to revise the plan of care had the potential for the resident to have unrealistic and/or unattainable goals and not to receive nutrition care in accordance with their needs.

Sources: resident's clinical records, Canadian Guidelines for Body Weight Classification in Adults: Quick Reference Tool for Professionals (Health Canada, 2021); interviews with the DOC, RD and other staff. [720920]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, specifically regarding nutrition interventions.

Rationale and Summary
A resident's care plan stated that they were to receive the specific food and fluid nutrition interventions at meals and snacks. The home's meal service and snack reports contained the same information.

The resident was observed to receive a regular meal without any changes as outlined in the meal service report. The dietary aide platting the meal was unaware that the resident required changes to their meal and was unsure how to implement the interventions as outlined on the meal service report.

The resident was also observed to receive food and fluids that did not comply with the nutrition interventions as outlined in their care plan.

A personal support worker stated that the resident received food and fluids as per their wishes, which did not always match the nutrition interventions.

The RD stated that they believed that the resident was receiving the nutrition interventions as outlined in their plan of care but acknowledged that there was room for improvement. The Food Service Manager (FSM) acknowledged that they did not know how the dietary aides would provide some of the nutrition interventions depending on the certain menu options.

Failure to provide nutrition interventions as set out in the resident's plan of care may have resulted in the resident not meeting their nutritional needs and/or meeting their goals.

Sources: resident's clinical records, meal and snack reports; meal and snack observations; interviews with the RD, FSM and other staff. [720920]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the fall prevention and management program, and skin and wound care program, as required in Ontario Regulations (O. Reg.) 246/22 s. 53 (1), including interventions, were documented for two different residents.

A. Rationale and Summary
A resident was deemed high risk for falls and had several fall prevention interventions detailed in their care plan. Their task list directed staff to check one intervention hourly and the other on all three shifts.

POC task documentation was reviewed from December 2022 to March 2023. Missing documentation for the intervention to be checked hourly was identified four times in December, 38 times in January, 26 times in February and 11 times in March. Missing documentation for the intervention to be checked on each shift was identified four times in January, three times in February and once in March.

A PSW stated that they do their checks but may not always have the time to document. The DOC acknowledged that they expected staff to complete their documentation in a timely manner.

Failure to document fall prevention interventions may have resulted in care not being provided as per the resident's needs.

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

B. Rationale and Summary
A resident's care plan indicated that they had a risk of impaired skin integrity and their task list required an intervention to be documented every shift. The resident's substitute decision maker (SDM) reported observing altered skin integrity and stated that they first observed it a few days prior.

Point of care (POC) task documentation was reviewed for two months following the resident's

admission. Missing documentation for the intervention was identified eight times during that time frame.

A PSW stated that they recalled some altered skin to the resident at that time. Another PSW acknowledged that they may not always have time to complete their documentation. The DOC acknowledged that skin integrity needed to be reported immediately and they expected staff to complete their documentation in a timely manner.

Failure to document interventions may have resulted in altered skin integrity going unnoticed or unreported.

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

WRITTEN NOTIFICATION: Nutritional Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (a)

The licensee failed to ensure that staff complied with policies and procedures for cleaning of equipment related to the food production system and dining and snack service.

Specifically, staff failed to comply with the home's procedures, in their Ware Washing Policy, revised January 2022, which outlined the manual and mechanical ware washing procedures that included to inspect for cleanliness and rewashing any items that are not clean.

Rationale and Summary
During the course of inspection, in three different resident home area (RHA) dining rooms, a total of 13 drinkware, specifically mugs, were wiped randomly with napkins and consistently resulted with dark residue markings.

The FSM and a dietary aide acknowledged the dark residue markings on napkins from washed mugs. FSM stated she would re-educate staff about cleaning, washing, and checking for cleanliness.

A memo to the dietary staff was posted for a mandatory meeting to review the procedures of the deep cleaning of dishes including cups, the morning and evening washing duties, and cleaning schedule. A posting by the dishwashing station was observed and stated that staff unloading the dishwasher to check cleanliness before putting on food carts.

There was an increased risk for contamination by staff not following ware washing procedures.

Sources: observations, Ware Washing Policy, NC-08-01-04, reviewed January 2022, interviews with FSM and other staff. [740765]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 10. Hand Hygiene Program, that the licensee shall ensure that the hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

ABHR with expiry dates of November 2022 were observed outside of two resident rooms with additional precautions. Three more ABHR were observed within the home with expiry dates of April 2022 and one ABHR with no expiry label.

The DOC acknowledged that the ABHR bottles were expired. The IPAC Lead stated that expired ABHR does not meet the efficacy of the required 70-90% alcohol content required.

Using expired ABHR may have increased the risk of transmission of infections.

Sources: observation of expired ABHR, Hand Hygiene Policy, IC-02-01-08, revised January 2023, and interviews with DOC and IPAC Lead. [740765]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.

The licensee failed to ensure that an acknowledgement receipt of a complaint concerning resident care or the operation of the home that could not be investigated and resolved within ten business days was

provided within ten business days.

Rationale and Summary
The home's Complaints and Customer Service Log in 2022 was reviewed and three complaints were not resolved within ten business days. The following did not include a provided acknowledgment of receipt of the complaint and an expected resolution date response within ten business days:

1. A January 2022 complaint, the follow-up response to the complainant was issued 18 business days later.
2. A September 2022 complaint, the follow-up response to the complainant was issued 37 business days later.
3. Another September 2022 complaint, the follow-up response to the complainant was issued 35 business days later.

As per the home's Complaints and Customer Service Policy, if an investigation was not completed within ten days, the complainant was to be contacted to indicate the investigation would be ongoing and would be provided an estimated date of completion. Moreover, each contact with the complainant should be recorded on the home's Complaint's Contact Form.

The DOC acknowledged the process to follow-up and reply to a complaint was ten business days. They could not provide evidence that complainants were contacted or provided an acknowledgement receipt of their complaints within ten business days. The DOC could not corroborate that a Complaint's Contact Form was completed.

Failure to provide an acknowledgement of receipt of complaints that could not be investigated and resolved within ten business days, put residents at risk for harm with complaints that concerned resident care or operation of the home.

Sources: Complaints and Customer Service Policy (RC-09-01-04, reviewed April 2022), Complaints and Customer Service Logs, and interview with the DOC. [740765]