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

Original Public Report

Report Issue Date: April 9, 2024

Inspection Number: 2024-1394-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Halton Healthcare LTC Inc.

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

Lead Inspector	**Inspector Digital Signature**
Emmy Hartmann (748)	EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2024.04.12 10:55:32 -04'00'

Additional Inspector(s)
Lillian Akapong (741771)
Patrishya Allis (000762)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-8, 11-14, 18-19, and 21, 2024.

The following intake(s) were inspected:

- Intake #00091718 was related to a fall of a resident resulting in injury.
- Intake #00095922 was related to a fall of a resident resulting in injury.
- Intake #00102577 was related to an injury to a resident with unknown cause.
- Intake #00105634 was related to an allegation of neglect of a resident.
- Intake #00107381 was related to Infection Prevention and Control.

- Intake #00107240 was related to a complaint regarding medication management, neglect, palliative care, and plan of care.
- Intake: #00107776 was related to a complaint regarding falls prevention and management, and plan of care.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Palliative Care
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's Power of Attorney (POA) was

notified when the resident had a change in their condition.

Rationale and Summary
The resident was placed in palliative care on an identified date. A staff member verified that the family wanted to be notified of any changes to the resident.

On an identified date, the resident was started on a treatment as a result of a change in their condition. The resident continued to have a decline in their condition through the identified timeframe.

There was no documentation of the family being notified of the resident's condition until about five hours after the resident had a change in condition.

As a result of this, the family was not able to participate in the development and implementation of the resident's palliative plan of care; including but not limited to, coming to the home to be by the resident's bedside.

Sources: A resident's progress notes; interviews with staff.
[748]

WRITTEN NOTIFICATION: Plan of care

NC #002 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 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, related to falls interventions.

Rationale and Summary
The resident's plan of care identified that they were to wear a device at all times. During an observation on an identified date and time, the inspector requested for a staff member to check if the resident was wearing the device. The staff member checked and acknowledged that the resident was not wearing the device.

During an interview on an identified date, a registered practical nurse (RPN) acknowledged that the resident was not wearing the device.

Failure for the resident to wear the device put the resident at risk for injury during a fall incident.

Sources: A resident's plan of care and progress notes, observation, and interviews with staff.
[741771]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care related to palliative care medications, were reassessed and revised when they could not be filled due to contraindications with the resident's condition.

Rationale and Summary
The resident was prescribed medications on an identified date.

The progress notes documented on the same date, identified that an RPN was informed by pharmacy that the medications could not be sent due to contraindications with the resident's condition. The RPN left a message for the prescribing physician, and informed the resident's POA.

The RPN identified that the doctor on-call should have been contacted at the time; however, they confirmed that they did not contact the doctor on-call when they did not hear back from the prescribing physician.

The doctor on-call verified that they were not called by the RPN on the identified date.

A registered nurse (RN) and the Director of Care (DOC) acknowledged that the resident's plan of care was not reassessed when medications could not be filled due to contraindications with the resident's condition.

As a result of this, the resident did not have medication in place if they needed it. This placed the resident at risk for unmanaged symptoms when they were in palliative care.

Sources: A resident's clinical records, the home's Physician On-Call schedule; interviews with staff.
[748]

WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was not neglected.

Ontario Regulation 246/22 defined neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

Rationale and Summary
The resident was placed in Palliative Care on an identified date. The family requested to be notified of any change in the resident's status while in palliative care.

The resident was prescribed medications on an identified date during the day shift; however, when the pharmacy informed the home that certain medications could not be filled due to contraindications with the resident's condition; there was no reassessment of the resident's plan of care.

Staff did not document that the resident was in pain; however, there was no pain assessment completed for the day, evening and night shift, as per the home's pain policy. There was a risk that the resident's pain was not identified as staff did not follow the home's policy to identify pain in residents.

The resident had a change in condition in the night of the identified date, requiring treatment. The family was not notified until early morning of the next day, which impacted the family's ability to participate in the development and implementation of the resident's palliative plan of care; including but not limited to, coming to the home to be by the resident's bedside.

The home did not follow their policy related to Physician's Orders by including the time when the order was written on an identified date. The physician's order not having the time the order was written could have impacted when the order was processed, including when it was transcribed. The order was not transcribed into the electronic medication administration records (eMAR) until the following day, when it should have been treated as urgent. The staff would not have been able to see the orders in the eMAR and this may have affected the administration of medications to the resident when the medications were needed.

The resident passed away on an identified date and time. Their well-being was jeopardized in their last hours, when the home failed to reassess the resident's plan of care when needed; involve the resident's family in the plan of care; follow policies related to pain, and medication management.

Sources: A resident's progress notes, assessments, physician's orders, eMAR, Pain Identification and Management Policy, Medication Management Policies; interviews with nurses, the consultant pharmacist, and the DOC.
[748]

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to comply with the pain management program that was developed and implemented in the home to identify pain in residents and manage pain.

Rationale and Summary
In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) b, the licensee was required to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, or put in place a program, that the program was complied with.

Specifically, the home did not comply with the home's Pain Identification and Management Policy within the home's pain program, which stated that a pain assessment was completed for 72 hours, when a new pain medication was started.

A nurse identified that the pain assessment was completed via the Pain/Palliation V5 tool in Point Click Care (PCC), and that a new pain assessment was completed when new pain medication was prescribed to a resident.

The resident was placed in palliative care, and prescribed pain medication on an

identified date, during the day shift; however, there was no pain assessment completed on the resident in PCC, and there was also no pain assessment completed in the evening shift and night shift.

The resident's pain may not have been captured when the home's pain policy was not followed. This put the resident at risk for discomfort when they were in palliative care.

Sources: A resident's assessments, the home's Pain Identification and Management Policy; interviews with RN #112 , and the DOC.
[748]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident was reassessed at least weekly by a member of the registered nursing staff when they exhibited an altered skin integrity.

Rationale and Summary
On an identified date, the resident was readmitted from the hospital following an injury. The initial skin and wound assessment was completed upon admission, and it was noted that the resident had an injury. No weekly skin and wound assessments were done following the initial assessment.

During an interview with an RPN on an identified date, they acknowledged that there was no weekly skin and wound assessment done after the resident returned from the hospital with a skin alteration.

Failure to complete weekly skin and wound assessments could put the resident at risk for infection and altered skin integrity.

Sources: Skin and wound Policy #RC-23-010, a resident's July 2023 TAR, weekly, initial and head to toe skin assessments for July 2023, progress notes, and interview with a registered staff.
[741771]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to carry out every standard or protocol issued by the Director with respect to infection prevention and control, the Director's issuance was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for long-term care homes, Standard 6.1, the licensee was required to ensure that Personal Protective Equipment (PPE) was available and accessible to staff and residents, appropriate to their role and level of risk.

Rationale and Summary
The COVID-19 guidance document for long-term care in Ontario specified that eye protection and n95 masks were required for all staff when providing care to residents with suspected COVID19. The home's droplet precautions policy required eye protection to be worn when within two meters of a resident with symptoms of an infection that can be transmitted via droplets.

On an identified date, a resident was in isolation under droplet and contact precautions, awaiting results of a PCR test. The inspector observed a staff member, enter the resident's room and was not wearing eye protection or an n95 mask as part of their PPE.

The signage on the resident's door indicated the full PPE and an n95 respirator were to be used prior to entrance. The following PPE and IPAC supplies were not available outside of the resident's room during observation: N95 masks, face shields, eye protection. This was confirmed by an RPN.

Additionally, the inspector did not observe face shields or eye goggles available outside of another resident's room, who was on droplet precautions, which was

confirmed by an RPN.

The DOC confirmed that staff were expected to comply with the PPE requirements based on the signage posted outside of residents' rooms.

Failure to have n95 masks and eye protection readily accessible and used in accordance with the Minister's Directives posed a risk of transmission of infectious agents.

Sources: observations; two residents' clinical records, COVID-19 Guidance Document: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities (June 2022), Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), Contact Precautions (IC-03-01-08, January 2024), Droplet Precautions (IC-03-01-09, January 2024); and interviews with staff. [000762]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. B.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee has failed to ensure that the response provided to the persons who made a written complaint concerning the care of a resident, included that the licensee believed the complaint to be unfounded, together with the reasons for the belief.

Rationale and Summary
A written complaint was received by the home on an identified date, concerning the care of a resident.

The home's complaint log identified that the result of the complaint was unfounded.

The DOC verified with the inspector that the response letter within the home's investigation package, did not include that the licensee believed the complaint to be unfounded, together with the reasons for the belief.

Sources: The home's complaint log, investigation package; interview with the DOC. [748]

WRITTEN NOTIFICATION: Medication Management System

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all

drugs used in the home.

The licensee has failed to comply with the written policies and protocols developed for the medication management system to ensure the accurate administration of all drugs used in the home.

Rationale and Summary
In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) b, the licensee was required to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, or put in place a system, that the system was complied with.

A: Specifically, the home did not comply with the home's Medisystem policy within the medication management system, which stated that medical directives must be entered by nursing in the eMAR.

A nurse identified that if a resident needed an identified treatment based on assessment, it would be administered to a resident. The use of the identified treatment was included in the medical directives document for each resident.

The progress notes identified that the resident was provided the identified treatment on an identified date and time; however, there was no entry into the eMAR about the use of the identified treatment.

The DOC verified that medical directives were entered into the eMAR when used, and this was not completed when the resident was provided the identified treatment on an identified date and time.

There was a risk to the continuity of care when the use of the identified treatment

was not entered into the eMAR by nursing.

Sources: A resident's progress notes, medical directives, and eMAR. the home's Medisystem Policy; interviews with a nurse, and the DOC.
[748]

B: Specifically, the home did not comply with the home's Medisystem policy within the medication management system, which stated that a physicians' order must contain the date and time the order was written.

The resident was prescribed medications related to palliative care on an identified date. The physician's order form did not include the time when the order was written.

The DOC verified that the time the order was written should have been included in the physician's order.

There was a risk to continuity of care when the time of the order was not included in the physician's order.

Sources: A resident's physician's orders, the home's Medisystem Policy; interview with the DOC.
[748]

WRITTEN NOTIFICATION: Medication management system

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that written policies and protocols for the home's medication management system was implemented with evidence-based practices, and, if there was none, in accordance with prevailing practices.

Rationale and Summary
The College of Nurses of Ontario (CNO) Documentation Practice Standard, stated that one of the ways nurses met the standard of ensuring Documentation presented an accurate, clear and comprehensive picture of the client's needs, the nurse's interventions and the client's outcomes; was by providing a full signature or initials, and professional designation with all documentation.

An interview with an agency nurse identified that agency nurses used a shared login with a shared first and last name.

A review of a resident's eMAR identified that medication was administered and signed by the shared login used by the agency nurse, with no designation.

A staff member identified that the shared login's first and last name was not of a real person, and used as a shared login for agency nurses.

The DOC verified that the administration of medications did not reflect who provided the medication in the eMAR, as it was not the nurses' name and designation that showed up on the eMAR.

There was a risk in the continuity of resident care when staff administering medication to residents were not providing their own signature, or initials, and professional designation in the eMAR.

Sources: A resident's eMAR, CNO Documentation Practice Standard, revised 2008; interviews with an agency nurse, staff in the home, and the DOC.
[748]

WRITTEN NOTIFICATION: Responsibilities of pharmacy service provider

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 129 1.
Responsibilities of pharmacy service provider
s. 129. Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:
1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.

The licensee has failed to ensure that their pharmacy service provider participated in the development of medication administration records.

Rationale and Summary
New medication orders for a resident for palliative care was prescribed on an identified date, during the day shift.

The resident's eMAR identified an order start date a day after the day it was prescribed in the evening shift.

The DOC and the consultant pharmacist verified that the orders should have been entered by the pharmacy on the same date the orders were prescribed, as they would have been considered urgent due to the orders being palliative care orders. They verified that the orders were not entered by pharmacy into the eMAR until the day after, in the evening shift.

As a result of the orders not being entered into the eMAR, the nurses were not able to document administration of medications into the eMAR. The progress notes identified that the resident was provided a medication to manage symptoms; however, this was not reflected in the eMAR.

This also put the resident at risk of not being given the medication they needed, as the nurses were not able to see the orders in the eMAR.

Sources: A resident's physician's orders, eMAR, progress notes; interviews with the consultant pharmacist, and the DOC.
[748]