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: August 22, 2024
Inspection Number: 2024-1394-0002
Inspection Type: Critical Incident
Licensee: Halton Healthcare LTC Inc.
Long Term Care Home and City: Wyndham Manor Long Term Care Centre, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 13-16, 20, 2024

The inspection occurred offsite on the following date(s): August 19, 2024

The following intake(s) were inspected:

- Intake: #00110595 [Critical Incident (CI) #2910-000011-24] - related to falls prevention and management.
- Intake: #00112154 [CI #2910-000013-24] - related to prevention of abuse and neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 protected from abuse by a staff member.

Rationale and Summary

O. Reg. 246/22 s. 2 (1) (a) defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

During care, a resident began to exhibit responsive behaviours. A staff intervened in attempt to stop these responsive behaviours. As a result of the actions taken by the staff, the resident was injured and experienced pain.

Sources: A resident's clinical records and interviews with the PSW and DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was reported to the Director immediately.

Rationale and Summary
The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care on a day in March 2024, for an incident of alleged/witnessed abuse. The Ministry's after-hours Action Line was called more than 12 hours after the incident occurred.

The DOC acknowledged that staff did not follow the reporting requirements and it was reported late.

Failing to report matters to the Director immediately, risk not addressing the matter on time.

Sources: The resident's progress notes, the CI report, the after-hours report, and an interview with the DOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident

has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that a post-fall assessment was conducted for a resident using a clinically appropriate assessment instrument that is specifically designed for falls.

Rational and Summary
A resident had a witnessed fall that resulted in an injury. A falls progress note was completed, however no post-fall assessment was completed under the assessments tab in PCC. The home's Falls Prevention and Management Program policy (March 2023) indicated a post-fall assessment tool to be completed after a fall.

The falls progress note did not include how the fall may have been prevented, a follow up plan, recommendations, and post-fall huddle participants and details which is indicated in the post-fall assessment tool.

By not using a clinically appropriate assessment instrument that is specifically designed for falls, a detailed and standardized assessment to ensure a comprehensive analysis of a fall was not captured.

Sources: Record review of the resident's assessments; Extendicare Falls Prevention and Management Program policy (March 2023); and interviews with the RN, DOC, and ADOC.

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