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
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Public Report

Report Issue Date: July 15, 2025
Inspection Number: 2025-1394-0004
Inspection Type: Critical Incident Follow up
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): July 9-11, 15, 2025.

The following intake(s) were inspected:

- Intake: #00147156 - a Critical Incident (CI) related to resident care and support services.
- Intake: #00149580 - a Follow-up to Compliance Order (CO) #001 from inspection 2025-1394-0003, Fixing Long-Term Care Act (FLTCA), 2021, s. 25 (1) Policy to promote zero tolerance, Compliance Due Date (CDD): July 14, 2025.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1394-0003 related to FLTCA, 2021, s. 25 (1)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure staff used safe transferring techniques when assisting a resident to transfer. Staff did not provide a resident with the correct level of assistance during a transfer and the resident sustained an injury.

Sources: Record reviews, interview.