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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Original Public Report

Report Issue Date: September 11, 2023	
Inspection Number: 2023-1394-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: Halton Healthcare LTC Inc.	
Long Term Care Home and City: Wyndham Manor Long Term Care Centre, Oakville	
Lead Inspector Emmy Hartmann (748)	**Inspector Digital Signature** EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2023.10.03 08:49:19 -04'00'
Additional Inspector(s) Dusty Stevenson (740739)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 25, 28-31, and September 1, 5-6, 2023.

The following intake(s) were inspected:

- Intake: #00094777, Proactive Compliance Inspection (PCI) for Wyndham Manor LTC Centre.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement

Residents' Rights and Choices
Pain Management
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)
O. Reg. 246/22, s. 168 (6) (c) i.

The licensee has failed to ensure that the home's Continuous Quality Improvement (CQI) initiative report included the name and position of the designated lead for the CQI initiative.

Rationale and Summary
The Assistant Director of Care (ADOC) and Director of Care (DOC) verified that the name and position of the designated lead, was not included in the home's report, which was posted within the home, and the home's website.

The DOC corrected this immediately and added the name and position of the designated lead to the home's report.

Sources: Review of CQI report; interviews with ADOC, DOC.
[748]

Date Remedy Implemented: September 5, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (r)

The licensee has failed to post an explanation of whistleblowing protection in the home.

Rationale and Summary:
It was observed that the whistleblowing protection policy was not posted in the home, nor within a binder in the front lobby where other mandatory postings were available.

On an identified date, the DOC acknowledged that the whistleblowing protection policy was missing from its usual location in the mandatory postings binder in the front lobby.

On an identified date, the whistleblowing protection policy was observed to be present in the binder with other mandatory postings in the front lobby.

Sources: Observations, interview with DOC.
[740739]

Date Remedy Implemented: September 6, 2023

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that changes made to a resident's dietary plan of care was implemented and consistent.

Rationale and Summary
According to the resident's clinical records, their diet was changed on an identified date.

The Meal Service Report for the resident's Dining Room, which provided direction to staff on a resident's diet, did not reflect the updated change.

On an identified date, the resident was observed being served a meal that was not reflective of their

current diet.

The Dietitian indicated that the clinical records and the Meal Service Report were not consistent with each other.

As a result of inconsistencies in the resident's plan of care, the resident was served the incorrect diet, placing them at risk.

Sources: A resident's clinical records, observation of meal service, interview with Dietitian.
[740739]

WRITTEN NOTIFICATION: Windows

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents cannot be opened more than 15 centimetres (cm).

Rationale and Summary
Inspector #740739 observed a window in a resident's room. The window was able to open up to 46 cm when fully opened and did not have a stopping mechanism in place to prevent it from opening more than 15 cm.

The Environmental Services Manager acknowledged that windows should not open greater than 15 cm and that the window in the resident's room was missing the stopping mechanism to prevent this.

Having a window that provided an opening greater than 15 cm may have presented a risk to resident safety as someone may attempt to exit the home through the window.

Sources: Observation of a resident's room, interview with Environmental Services Manager.
[740739]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee has failed to implement an intervention to manage the dietary needs of two residents.

Rationale and Summary
According to the plan of care for two residents, they required a specific intervention.

The two residents were observed not receiving the intervention. A staff member verified that the specific intervention was available.

The Dietary Manager (DM) acknowledged that the two residents did not receive the specific intervention to manage their dietary needs.

Sources: Observation of meal service, clinical records of two residents, interview with DM and a staff member.
[740739]