Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 14 and 15, 2011	2011_147_2656_15Mar103942 2011_147_2656_14Mar141818	Complaint – H-00278 and H-00337 Complaint – H-00250

Licensee/Titulaire
Tyndall Nursing Home Limited
1060 Eglinton Avenue East
Mississauga, ON
L4W 1K3
Fax: 905-629-9346

Long-Term Care Home/Foyer de soins de longue durée
Tyndall Nursing Home
1060 Eglinton Avenue East
Mississauga, ON
L4W 1K3
Fax: 905-629-9346

Name of Inspector(s)/Nom de l'inspecteur(s)
Laleh Newell - 147

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct Complaint inspection.

During the course of the inspection, the inspector spoke with:

Director of Care and staff.

During the course of the inspection, the inspector:

Reviewed resident's clinical charts, reviewed home's policy and procedure related to Falls Prevention, reviewed internal incident and investigation reports, observed care, toured the home, and observed staff in routine duties.

The following Inspection Protocols were used during this inspection:

Fall Prevention
Personal Support Services
Skin and Wound Care

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
2 VPC
2 CO: CO #001 and #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with - O. Reg. 79/10, s. 8(1)(b)

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(b) is complied with

Findings:

1. According to the home's policy and procedure - Fall Risk Assessment, "the Registered Nurse (RN) or Registered Practical Nurse (RPN) is to complete an Internal Incident Report and forward it to the Director of Nursing (DON)". The Fall Risk Assessment policy also states that "it is expected that any falls is investigated and appropriate interventions implemented to eliminate and/or minimize recurrence of falls".
2. An identified resident had six falls in 2 months in 2010. The home only completed one Internal Incident Report related to one of the six falls.
3. An identified resident had eleven falls in 4 months. The home failed to complete any Internal Incident Report related to any of the eleven falls.
4. The home also failed to investigate any of the two residents' falls to ensure appropriate interventions were put in place to eliminate and/or minimize recurrence falls.

Inspector ID #:	147

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff comply with the Falls policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with - O.Reg 79/10, s. 30(2)

The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Findings:

1. An identified resident admitted to the home in 2010 with a history of Urinary Tract Infections (UTI).
2. Resident was exhibiting resistive behaviours during care. Resident was assessed by physician and orders were given to collect a specimen. However, the specimen was not collected by staff until several days later. Sample was returned from the lab indicating it was contaminated and to repeat the test. The sample was repeated on the following day and the results from the lab indicated it was again contaminated.
3. Progress notes for the resident indicated the resident continued to exhibiting resistive behaviours no further interventions and reassessment were documented for the resident.
4. Resident was seen by Nurse Practitioner (NP) in 2010 due to increased weakness and being more confused. NP ordered to collect a specimen.
5. The sample was not collected by staff again until few days later, no documentation to support resident was resistive towards staff related to obtaining the sample. The sample returned from the lab indicating the sample was contaminated and required to be repeated. The sample was repeated again and results from the lab again indicated it was again contaminated.
6. No further samples were collected or repeated and there is no evident in the progress notes to indicate any interventions were started related to the resident's response to the change in behaviour.
7. The resident was sent to hospital in 2011 due to sudden changes in condition and diagnosed with an infection.

Inspector ID #:	147

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with all residents include assessment, reassessment, intervention and the response to the intervention are documented to be implemented voluntarily.

WN #3: The Licensee has failed to comply with - O.Reg. 79/10, s. 48(1)(1)

Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. **A falls prevention and management program to reduce the incidence of falls and the risk of injury.**

Findings:

1. Interview with Director of Nursing (DON) indicate the home has not had the opportunity since July 1, 2010 to develop and implement an interdisciplinary program related to falls prevention and management program in the home to reduce the incidences of falls and the risk of injury.

Inspector ID #:	147

CO # - 001 will be served on the licensee. Refer to the "Order of the inspector" form.

WN #4: The Licensee has failed to comply with - O. Reg 79/10, s. 49(2)
Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Findings:

1. An identified resident had six falls in an eight week period. The resident was initially assessed at time of admission related to falls and deemed at high risk for falls. However, the resident was not reassessed after each fall and there is no documented evidence to indicate a clinically appropriate assessment instrument that is specifically designed for falls was used.
2. An identified resident had eleven falls in an eighteen week period. The resident was not reassessed after each fall and there is no documented evidence to indicate a clinically appropriate assessment instrument that is specifically designed for falls was used.

Inspector ID #:	147

CO # - 002 will be served on the licensee. Refer to the "Order of the inspector" form.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Revised for the purpose of publication - Sept 29, 2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

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Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Laleh Newell	**Inspector ID #**	147
Log #	H-00120, H-00337 and H-00250		
Inspection Report #:	2011_147_2656_15Mar103942 2011_147_2656_14Mar141818		
Type of Inspection:	Complaint		
Date of Inspection	March 14 and 15, 2011		
Licensee:	Tyndall Nursing Home 1060 Eglinton Avenue East, Mississauga, ON L4W 1K3		
LTC Home:	Tyndall Nursing Home 1060 Eglinton Avenue East, Mississauga, ON L4W 1K3		
Name of Administrator:	Brandeis D. Jolly		

To Tyndall Nursing Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: The Licensee has failed to comply with - O.Reg. 79/10, s. 48(1)(1)

Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. **A falls prevention and management program to reduce the incidence of falls and the risk of injury.**

Order:

The licensee shall prepare and submit a plan to ensure that an interdisciplinary program is developed and implemented in the home related to falls prevention and management program to reduce the incidence of falls and the risk of injury shall be implemented.

The licensee shall submit the plan to this inspector at Laleh.newell@ontario.ca by April 19, 2011,

Grounds:	
1. Interview with Director of Nursing (DON) indicate the home has not had the opportunity since July 1, 2010 to develop and implement an interdisciplinary program related to falls prevention and management program in the home to reduce the incidences of falls and the risk of injury.	
This order must be complied with by:	July 4, 2011

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: The Licensee has failed to comply with - O. Reg 79/10, s. 49(2)

Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Order:

The licensee must ensure all residents who have fallen are assessed and where indicated a clinically appropriate assessment instrument that is specifically designed for falls is used.

Grounds:

1. An identified resident had six falls in an eight week period. The resident was initially assessed at time of admission related to falls and deemed at high risk for falls. However, the resident was not reassessed after each fall and there is no documented evidence to indicate a clinically appropriate assessment instrument that is specifically designed for falls was used.
2. An identified resident had eleven falls in an eighteen week period. The resident was not reassessed after each fall and there is no documented evidence to indicate a clinically appropriate assessment instrument that is specifically designed for falls was used.

This order must be complied with by:	Immediately

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

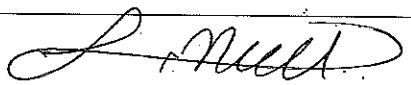
The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 5th day of April, 2011.	
Signature of Inspector:	
Name of Inspector:	Laleh Newell
Service Area Office:	Hamilton Service Area Office