Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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
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HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 21, 2016;	2016_449619_0012 (A1)	008586-16	Critical Incident System

Licensee/Titulaire de permis

TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

Long-Term Care Home/Foyer de soins de longue durée

TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMANTHA DIPIERO (619) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Issued on this 15 day of March 2017 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMANTHA DIPIERO (619) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 30-31, 2016.

The following critical incident inspections were completed: #008586-16 related to responsive behaviours and #025923-15 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Behavioural Support Ontario (BSO) nurse, registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), and residents. The inspector also toured the facility, observed the provision of care, and reviewed the home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the homes policy titled, "Resident Non-Abuse", index # HR-K-30, last revised February 2012, stated that "the Ministry of Health and Long Term Care will be notified of any incidents of resident abuse or suspected resident abuse at the earliest possible time". A review of the progress notes and critical incident reports submitted by the home in relation to an episode of responsive behaviours, which were suspected to be abuse by resident #001, confirmed that a critical incident occurred on an identified date in September 2015, was reported to the Ministry more than three days after the incident occurred in September 2015. A second incident related to responsive behaviours occurred in March 2016, was reported to the Ministry more than four days after the incident occurred in March 2016. An interview with the DOC confirmed that the home did not submit the critical incident report to the Director at the earliest possible time and therefore did not comply with the home's abuse policy. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to protect a resident from abuse by anyone.

On an identified date in March 2016, resident #001 was discovered in a room with resident #002 and was observed displaying responsive behaviours towards a co-resident. Resident #002 was not considered capable of consenting. Interview with staff #101, #104, and #105 indicated that resident #001 had displayed responsive behaviours prior to the incident in March 2016. Interview with BSO confirmed that in September 2015, resident #001 displayed responsive behaviours towards resident #002, and confirmed that no referral for behavioural interventions were received and they were unaware of the ongoing behaviours. A review of the resident's written plan of care did not include any identification of inappropriate behaviours or related interventions. This was confirmed by RPN #101. A review of the homes policy titled "Responsive Behaviours", index #SP-B-05, last updated January 2014, stated "for the Individual resident, staff are responsible for the assessment, interventions, resident's responses to the interventions, reassessment, and plan of care revisions". An interview with the DOC confirmed that the home did not complete a behavioural assessment, and that no interventions were put in place to mitigate these behaviours for resident #001 in relation to the ongoing responsive behaviours, and as a result, resident #002 was not protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

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 with s. 19(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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to these behaviours, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions.

Resident #001 was noted to display and engage in responsive behaviours towards resident #002. The earliest documented incident occurred in September 2015, with a second documented incident occurring in March 2016. Interview with PSW #104 and RPN #101 indicated that staff on the unit were aware of the resident's ongoing responsive behaviours but that no referral to the Behavioural Support Ontario (BSO) nurse was made. A review of the home's policy titled "Responsive Behaviours", index #SP-B-05, last updated January 2014, stated "staff must identify the causes and triggers, and develop strategies for prevention". A review of resident #001's written plan of care last revised in September 2015, and February 2016, indicated that no changes were made to resident #001's written plan of care in response to the responsive behaviours. Interview with BSO RPN confirmed that Direct Observational Screening (DOS) monitoring took place for seven days after each incident occurred and that no re-assessments or interventions were completed by staff in relation to resident #001's responsive behaviours. An interview with the DOC confirmed that the resident was not re-assessed when displaying responsive behaviours and that no strategies, including identification of behavioural triggers and interventions were implemented. [s. 53. (4)]

Additional Required Actions:

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 with r. 53(4) the licensee shall ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to maintain confidentiality with respect to personal health information within the meaning of the Personal Health Information Protection Act, 2004.

On an identified date in March 2016, at a nursing station it was observed that the narcotic medication book which holds the personal health information for all residents on the living unit who require narcotic medications, was left unattended. Inspector reviewed the narcotic medication book which contained the following medication information:

Resident #003
Resident #004
Resident #005
Resident #006
Resident #007
Resident #008

Interview with RPN #102 confirmed that the narcotic medication book contained the personal health information of six residents and that the book should have been locked in the medication cart while not in use by staff. A review of the home's policy titled "Medication/Treatment Standards", index #NAM-G-05, last revised January 2014, stated that "The medication cart/module must be...locked when unattended or out of sight". An interview with the DOC confirmed that the narcotic medication book should not have been left unattended as it contained the personal health information of six residents and that the home did not protect the resident's rights to privacy as it pertained to the Personal Health Information Protection Act. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #001 was noted to display and engage in responsive behaviours towards resident #002. The earliest documented incident occurred in September 2015, with a second documented incident occurring in March 2016. Interview with PSW #104 and RPN #101 indicated that staff on the unit were aware of the resident's ongoing responsive behaviours and indicated that no changes had been made to the resident's plan of care. A review of resident #001's written plan of care last updated September 2015, and interview with BSO RPN confirmed that no changes were made to the plan of care in response to the resident's ongoing responsive behaviours. An interview with the DOC confirmed that when the resident's care needs changed, the resident was not reassessed and the plan of care was not reviewed or revised. [s. 6. (10) (b)]

Issued on this 15 day of March 2017 (A1)

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : SAMANTHA DIPIERO (619) - (A1)

Inspection No. / No de l'inspection : 2016_449619_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 008586-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Nov 21, 2016;(A1)

Licensee / Titulaire de permis : TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3

LTC Home / Foyer de SLD : TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patricia Bedford

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To TYNDALL NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the home complies with all aspects of the Abuse and Neglect policy, by ensuring the Executive Director immediately and directly reports any incident of alleged or witnessed abuse to the Ministry of Health and Long Term Care. The plan is to be submitted by August 1, 2016 via e-mail to samantha.dipiero@ontario.ca.

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s. 20(1) of the Act, in respect of the actual harm that resident #001 experienced, the scope of one isolated incident, and the Licensee's history of non-compliance (CO) on the April 21, 2015, and March 21, 2013, Resident Quality Inspections with s. 20(1) related to the prevention of abuse.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the homes policy titled, "Resident Non-Abuse", index # HR-K-30, last revised February 2012, stated that "the Ministry of Health and Long Term Care will be notified of any incidents of resident abuse or suspected resident abuse at the earliest possible time". A review of the progress notes and critical incident reports submitted by the home in relation to an episode of responsive behaviours, which were suspected to be abuse, by resident #001 confirmed that a critical incident occurred in September 2015, and was not submitted to the Ministry more than three days after the incident occurred. A second incident related to responsive behaviours occurred in March 2016, and was not reported to the Ministry for more than four days after the incident occurred. An interview with the DOC confirmed that the home did not submit the critical incident report to the Director at the earliest possible time and therefore did not comply with the home's abuse policy. (619) (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Sep 30, 2016(A1)

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 services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15 day of March 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SAMANTHA DIPIERO

Service Area Office /
Bureau régional de services : Hamilton