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 sous la Loi de 2007 sur 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2018	2018_644507_0018	019161-18, 020353-18	Complaint

Licensee/Titulaire de permis

Tyndall Seniors Village Inc.
108 Jensen Road LONDON ON N5V 5A4

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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 8, 9, 10, 14 & 15, 2018.

The following complaint was inspected during this inspection:
#020353-18 related to alleged resident neglect and abuse, Residents' Bills of Rights, transferring and positioning technique, continence care and bowel management, dining and snack service, bathing, oral care, availability of supplies and infection prevention and control program.

The following critical incident report was inspected concurrently with the complaint inspection:
#019161-18 related to CIS #2656-000020-18 related to alleged staff to resident abuse.

Inspector Ivy Lam (646) was part of the inspection team. The following findings identified for non-compliances were collected by Inspector #646:
- resident #001 related to LTCHA s. 6 (4) (a), s. 6 (10) (b) and O. Regulation 79/10 s.36,
- resident #002 related to O. Regulation 79/10 s. 73 (1) 9, and
- resident #003 related to LTCHA s. 6 (10) (b).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Student Personal Support Worker (SPSW), Physiotherapist (PT), Registered Dietitian (RD), Dietary Services Manager (DSM), Dietary Aide (DA), Housekeeping Aide (HA) and residents.

The inspectors conducted observations of staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A) On an unidentified date, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint alleging an unidentified resident was transferred using unsafe transfer technique. Resident #006 was randomly selected to be observed during transfer.

On an identified date and at an identified approximate time, the inspector observed staff #110 and #111 transferring resident #006 from bed to chair with a mechanical lift and a sling. The inspector observed the hem of the sling was a specific colour, and the label attached to the sling indicated it was a specific size (size A) sling.

In an interview, staff #111 stated that resident #006 required two staff for assistance with transfer, using a mechanical lift and a size A sling; and the sling used for transferring resident #006 on the above mentioned identified date was a size A sling. Staff was not able to tell the inspector where the information was found in regards to the size of sling for resident #006.

Record review of the written plan of care completed approximately two months prior to the inspection date for resident #006 indicated the resident required two person assistance with the use of a mechanical lift for transfer. There was no information regarding the size of sling to be used for transferring resident #006 in the resident's written plan of care.

In an interview, staff #114 stated that staff have been using size A slings for transferring resident #006, and staff usually did not include the size of sling in the resident's written plan of care.

In an interview, staff #124 stated that the size of sling used for transferring resident #006 should be included in the resident's written plan of care for staff to follow to ensure resident's safety.

B) Resident #008 was randomly selected as a result of non-compliance identified with resident #006.

Record review of the written plan of care completed approximately two months prior to the inspection date for resident #008 indicated that the resident required two person assistance with the use of a mechanical lift for transfer. There was no indication of the size of sling to be used for transferring resident #008 in the resident's written plan of care.

In an interview, staff #111 stated that resident #008 required a specific size (size A) of sling for transfer. Staff #111 was not able to tell the inspector where the information was found in regards to the size of sling for resident #008.

In an interview, staff #114 stated that staff have been using size A slings for transferring resident #008, and staff usually did not include the size of sling in the resident's written plan of care.

In an interview, staff #124 stated the size of sling used for transferring resident #008 should be included in the resident's written plan of care for staff to follow to ensure resident's safety. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

Resident #001 was randomly selected as a result of non-compliance identified with resident #006.

Review of resident #001's most recent written plan of care on PointClickCare (PCC) completed approximately one month prior to the inspection date indicated that resident #001 required two-person physical assistance, and to use the mechanical lift for transfer as needed.

Review of the most recent Achieva Physiotherapy Quarterly Re-assessment dated approximately six weeks prior to the inspection date for resident #001 indicated that the resident required a mechanical lift for toileting, and two-person assist in and out of bed.

On an identified date and at an identified approximate time, in resident #001's room, Inspector #646 observed staff #102 providing assistance using a one-person manual transfer, to transfer resident #001 from bed to chair.

In an interview, staff #102 stated that staff would determine whether resident #001 needed a one or two-person transfer from bed to chair based on the resident's level of alertness. Staff #102 also stated that staff have been providing one-to-two person manual transfer in transferring resident #001 from bed to chair for approximately two months. Staff #102 said that they did not check the resident's kardex prior to providing care on the above mentioned identified date, and that the kardex needed to be updated as the resident was able to do one-to-two person manual transfer from bed to chair.

In an interview, staff #128 stated that resident #001's written plan of care needed to be updated because resident #001's current condition required one-to-two person physical assistance.

In an interview, staff #129 stated that it was their recommendation to use two-person manual transfer for resident #001 for transfer, and it was not safe for the resident to have

one-person manual pivot transfer. Staff #129 further stated that staff should refer to the physiotherapist (PT) for assessment, instead of stepping up to go from two-person to one-person manual transfer for resident #001. In addition, staff #129 stated that staff should inform the nurses if residents' care needs changed.

In an interview, staff #124 stated that staff should collaborate in the assessment of the resident's care, staff should follow the resident's written plan of care, and report to the nurse if the resident's status changed. Then the nurse should send a referral to the PT for reassessment, and this was not done for resident #001 with regards to their care needs for transferring. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Review of resident #001's most recent written plan of care completed approximately one month prior to the inspection date indicated that the resident required assistance on and off the toilet using a specific type of mechanical lift (type A), with two-person physical assistance.

Review of the most recent Achieva Physiotherapy Quarterly Re-assessment dated approximately six weeks prior to the inspection date for resident #001 indicated that the resident required another type of mechanical lift (type B) for toileting, and two-person assist in and out of bed.

On an identified date and at an identified approximate time, Inspector #646 observed staff #102 and #112 assisting resident #001 with toileting. Inspector #646 observed that staff #102 and #112 used a type B mechanical lift to transfer resident #001 from wheelchair to toilet. In interviews, staff #102 and #112 stated that resident #001 required a type B mechanical lift for transfer from toilet to wheelchair.

In an interview, staff #128 stated that the written plan of care on the PCC was not up-to-date as the above mentioned PT assessment indicated that the resident required a type B mechanical lift for toileting; it was not reflected in resident #001's written plan of care accordingly.

In an interview, staff #129 stated that staff had informed them that resident #001 was able to use a type B mechanical lift instead of a type A mechanical lift for transfer for

toileting, and as per the resident's most recent Acheiva Physiotherapy Quarterly assessment, a type B mechanical lift was recommended to be used for toileting the resident.

In interviews, staff #129 and #124 stated that it was the home's process for the nurses to update the resident's written plan of care if the resident's care needs change, and that this was not done for resident #001 in regards to transferring for toileting.

B) A complaint was received by the MOHLTC on an identified date alleging improper feeding technique for residents.

On an identified date, Inspector #646 conducted a meal service observation in an identified dining room and observed that resident #003 was provided their entrée on a regular plate, and staff #102 was observed to be feeding the resident.

Review of the identified dietary binder indicated resident #003 was to receive a specific assistive device. Review of resident #003's most recent written plan of care completed approximately two weeks prior to the inspection date indicated that the resident required assistance for feeding, but did not include information related to the use of the specific assistive device.

In an interview, staff #102 stated that they had never seen resident #003 using the specific assistive device.

In an interview, staff #128 stated that resident #003 required assistance for feeding. Staff #128 further stated that they had not seen resident #003 using the specific assistive device before, and that the resident's written plan of care on PCC did not indicate the resident used an assistive device for eating.

In an interview, staff #130 stated that the residents who were able to eat independently were provided with assistive devices, and if the resident needed assistance for feeding, they would not need the specific assistive device. Staff #130 further stated that, as per resident #003's current written plan of care on PCC, the resident received assistance for feeding, the specific assistive device was no longer necessary. Staff #130 stated the above mentioned identified binder in the servery should be updated to indicate that the specific assistive device was no longer necessary for resident #003, and that this was not done. [s. 6. (10) (b)]

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 to ensure that:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, and
- the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) A complaint was received by the MOHLTC on an identified date alleging an unidentified resident was transferred using unsafe transfer technique. Resident #006 was randomly selected to be observed during transfer.

On an identified date and at an identified approximate time, the inspector observed staff #110 and #111 transferred resident #006 from bed to wheelchair with a mechanical lift and a sling. The inspector observed the hem of the sling was a specific colour.

In an interview, staff #111 stated that resident #006 required two staff for assistance with transfer, using a mechanical lift and a specific size (size A) sling; and the sling used for transferring resident #006 on the above mentioned date was a size A sling. Staff #111

was not able to tell the inspector how to identify the size of the sling. Staff #111 was not able to tell the inspector where the information was found in regards to the size of sling needed for resident #006.

In an interview, staff #114 stated that staff have been using size A slings for transferring resident #006, and staff usually did not include the size of sling in the resident's written plan of care. Staff #114 stated that the size of sling was determined by the resident's weight, and the colour of the hem of the sling indicated the size of the sling, and the guide was attached to the back of each sling. The guide included the colour chart and the weight ranges for a particular size of sling. Staff #114 and the inspector observed the label indicating the sizes, the colours of the hems and the related weight ranges.

Staff #114 stated that according to resident #006's current weight and the guide, size B slings should be used for transferring resident #006 with a mechanical lift. Staff #114 stated that an incorrect size of sling had been used for transferring resident #006.

In an interview, staff #124 stated that the incorrect size of sling had been used for transferring resident #006, and this was not a safe practice for transferring the resident.

B) Resident #001 was randomly selected as a result of non-compliance identified with resident #006.

Review of resident #001's most recent written plan of care on PCC completed approximately one month prior to the inspection date indicated that resident #001 required assistance for transferring. The written plan of care further stated that the resident required two-person physical assistance, and to use a type A mechanical lift for transfer as needed.

Review of the most recent Achievea Physiotherapy Quarterly Re-assessment dated approximately six weeks prior to the inspection date for resident #001 indicated resident #001 required a type B mechanical lift for toileting, and two-person assistance in and out of bed.

On an identified date and at an identified approximate time, Inspector #646 observed staff #102 providing assistance using a one-person manual transfer when transferring resident #001 from bed to wheelchair.

In an interview, staff #102 stated that staff determined whether resident #001 needed a

one or two-person transfer from bed to chair based on the resident's alertness.

In an interview, staff #129 stated that it was their recommendation to use two-person manual transfer for resident #001 for transfer, and that it was not safe for the resident to have an one-person manual pivot transfer. Staff #129 further stated that staff should refer to the PT for assessment instead of stepping up to go from a two-person to an one-person manual transfer.

In an interview, staff #124 stated that staff should follow the resident's written plan of care for the resident's safety. [s. 36.]

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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date alleging improper feeding technique for residents.

Review of resident #002's written plan of care completed on an identified date indicated that the resident was to be provided a specific assistive device as their adaptive aid.

Review of an identified dietary binder in an identified servery indicated resident #002 required assistive devices, including the above mentioned specific assistive device.

On an identified date, Inspector #646 conducted the meal service observation in an identified dining room, and the inspector observed that resident #002 did not receive the specific assistive device.

In an interview, staff #115 who served resident #002 the meal service on the above mentioned identified date, stated resident #002 should have the specific assistive device as per the dietary binder, but staff #115 did not provide resident #002 the specific assistive device. In an interview, staff #116 stated that staff #115 had forgotten to provide resident #002 with their specific assistive device on the above mentioned identified date. [s. 73. (1) 9.]

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 residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

Issued on this 24th day of September, 2018

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

Original report signed by the inspector.