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 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 11, 2019	2019_767643_0007	002861-19	Critical Incident System

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

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 13, 14, 15 and 22, 2019.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), and personal support workers (PSW).

During the course of the inspection the inspector conducted observations of provision of care, review of resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. 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 :

1. The licensee has failed to ensure that residents are free from neglect by the licensee

or staff in the home.

Neglect as outlined in section 2. (1) of the Regulation (O. Reg. 79/10) means the failure to provide a resident with the treatment, care services or assistance required for health, safety, or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident System report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), concerning improper or incompetent care of resident #010 which resulted in harm or risk to the resident. The CIS indicated that on an identified date, resident #010's family member visited the home and was informed by registered staff resident #010 was not feeling well and a specified laboratory diagnostic test would be carried out to rule out an identified condition.The test was conducted on the following day. The corresponding laboratory report for the initial portion of the specified diagnostic test was sent to the home the following day after the test, and report for the second portion of the diagnostic test was sent to the home two days after the test was conducted. The CIS indicated that the result, which was abnormal, was placed in the physician binder with no action taken. The NP in the home assessed resident #010 five days following delivery of the second portion of the laboratory results and sent the resident to hospital for assessment.

Review of resident #010's health records showed they were admitted to the home with a specified medical device in place at all times.

Review of resident #010's treatment administration record (TAR) showed an order to change the specified medical device every six weeks and as needed (PRN). Resident #010's TAR showed the medical device was changed ten weeks prior to transfer to hospital, by RN #104. Per the TAR the next scheduled medical device change was on an identified date six weeks later as ordered, which was coded as refused. Progress notes for resident #010 showed that on the date of the scheduled medical device change, RN #121 made three attempts to carry out the procedure and the resident refused each time. Progress notes and the TAR failed to reveal any further attempts to change resident #010's specified medical device until one day prior to their transfer to hospital, ten weeks following the prior change. Unit report work sheet from the date of the scheduled medical device change, showed that on an identified shift, resident #010 refused the medical device change. Unit report work sheet from the following shift showed resident #010 required a medical device change and had refused on the previous shift. No further notation in the unit report work sheet was identified regarding resident #010's medical

device change.

In an interview, RN #121 indicated that they had been asked by registered staff on the unit on the above date of resident #010's scheduled medical device change to carry out the procedure, and had not been able to do so as the resident had refused several times shouting "no". RN #121 indicated that the staff on the unit should communicate to the oncoming shift using the shift report and verbally that the order was not able to be carried out and to re-attempt until it could be successfully changed. RN #121 indicated they did not return to work until three days later, and had not followed up to see if the resident's medical device change had been carried out.

Review of resident #010's progress notes showed that 15 days prior to transfer to hospital, they had exhibited identified responsive behaviours toward a co-resident. Physician order form showed that two days following the above mentioned behaviour, an order was written for the specified diagnostic laboratory testing. Unit report work sheet from the date of the physician order showed a notation to conduct a specified diagnostic test for resident #010. Further review of unit report worksheets on subsequent dates did not show communication regarding diagnostic testing for resident #010. Worksheet for diagnostic testing showed a test was ordered to be conducted on the date of the physician order, and not done until six days later. The worksheet further showed the laboratory result was received 13 days after the physician order, by RN #104. Laboratory results for the diagnostic test showed specified abnormalities for both initial and second portions of the test.

In interviews, RPN #103 and RPN #105 indicated that they were not sure why the diagnostic test was not done over the six days following the order. Both RPNs indicated that the home's process was that when a resident needs to have diagnostic testing, the order would be written in the lab binder, and communicated via shift report to the next shift until completed. They were not aware of when the communication was missed regarding the diagnostic testing for resident #010. RPN #103 and RPN #105 indicated they were not aware of laboratory results being received on the two dates mentioned above, and had not reviewed them at that time.

In an interview, RN #104 indicated that resident #010 had a physician order written for diagnostic testing on the above identified date, which was collected six days later. RN #104 reported that when they returned to work 13 days after the physician order was written, resident #010 had an identified abnormality in their vital signs, and they requested that the laboratory fax the results of the diagnostic test to the home. RN #014

was not aware if anyone at the home had received and reviewed the lab results in the week prior. RN #104 indicated that if staff noted any abnormalities in the resident's specified monitoring data that was collected each shift, that registered staff should follow-up. RN #104 indicated they had not received any report of abnormalities in resident #010's monitoring data.

Progress notes and unit report worksheets for resident #010 indicated there were five occasions in which the monitoring data showed abnormalities following the physician order for diagnostic testing.

Progress notes and interview with RN #108 indicated that on the day prior to resident #010's transfer to hospital, they had been asked to assist with the resident as the previous shift had reported an abnormality with the monitoring data. RN #108 indicated they had attempted twice to perform a procedure to correct the abnormality but attempts were unsuccessful. RN #108 then proceeded to carry out a change of identified medical device. RN #108 indicated that resident #010 additionally had an abnormality in the monitoring data two shifts prior, which was possibly symptomatic of an identified condition and that a resident could be at risk for the identified condition if the medical device in place was not changed regularly.

In an interview, NP #106 indicated resident #010 had been referred to them for assessment on the date of transfer to hospital, as the resident showed identified symptoms and had not been eating well for the past two days. NP #106 indicated that upon assessment the resident showed additional clinical symptoms, and was moaning upon palpation. NP #106 indicated that the abnormalities in the diagnostic test results were potentially indicative of the above specified medical condition. NP #106 indicated at that point they wrote an order for a specified medication initially, then discussed with the care team and wrote an order to send resident #010 to hospital for treatment.

Review of documentation from the hospital showed that resident #010 had been admitted to hospital the following day after arriving to the emergency room and was diagnosed with a systemic medical condition. Resident #010 was seen by palliative care service two weeks later, and prognosis was poor according to the medical service. Progress notes showed resident #010's son informed the home the resident had passed away in hospital 19 days after being sent from the home for treatment.

In an interview with the DOC, they indicated that resident #010's son had reported to them that the diagnostic test should have been conducted, and wanted to know why it

took eight days to receive a result and treatment. The DOC indicated they investigated the matter and found it was not conducted until six days after being ordered by the physician, and was unable to determine who placed the laboratory results in the physician binder. The DOC acknowledged that during the two week period following the physician order for diagnostic testing, there were several occasions where abnormalities were found with resident #010's monitoring data. The DOC indicated that the need for the resident's medical device change should have been communicated shift to shift until it could successfully be completed, and it had not been followed up on after the initially scheduled device change was refused. As resident #010's medical device was not changed as scheduled, and not changed for the next 20 days, the specimen for diagnostic testing was not collected as ordered for six days, and there was no action to address the abnormal result of the abnormal diagnostic test once received; the DOC acknowledged that this constituted neglect of resident #010. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 20th day of March, 2019

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

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

Ministère de la Santé et des Soins de longue durée

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
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ADAM DICKEY (643)
Inspection No. / No de l'inspection :	2019_767643_0007
Log No. / No de registre :	002861-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 11, 2019
Licensee / Titulaire de permis :	Tyndall Seniors Village Inc. 108 Jensen Road, LONDON, ON, N5V-5A4
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

To Tyndall Seniors Village Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 19. (1).

Specifically the licensee must:
1) Ensure for all residents who refuse ordered treatment administration including medical device changes, the refusal and required treatment is communicated to oncoming registered staff to ensure that the resident is re-approached to complete the treatment administration as ordered;
2) Ensure for all residents that diagnostic testing as ordered by a physician or Nurse Practitioner are conducted as ordered, and if unsuccessful, ongoing communication amongst registered staff on all shifts to collect until completed as ordered;
3) Implement an auditing system to ensure that for all residents registered staff are tracking and conducting diagnostic testing as ordered by the physician, and also tracking the receipt and review of laboratory results for diagnostic tests; and
4) Maintain a written record of audits completed, including date of audit, resident name, the name and designation of the person completing audit, and the outcome of audit.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are free from neglect by the licensee or staff in the home.

Neglect as outlined in section 2. (1) of the Regulation (O. Reg. 79/10) means the failure to provide a resident with the treatment, care services or assistance required for health, safety, or well-being, and includes inaction or pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

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The severity of this issue was determined to be a level 3 as there was actual harm to resident #010. The scope of the issue was a level 1 as it related to one of the three residents reviewed. The home had a level 4 compliance history; despite MOHLTC actions non-compliance continued with the original area of non-compliance in the last 36 months for LTCHA 2007, c. 8. s. 19. (1) which included:
- Voluntary plan of correction (VPC) issued June 7, 2016 (2016_449619_0012);
- Compliance Order (CO) issued December 1, 2017 (2017_544527_0007); and
- VPC issued June 8, 2018 (2018_420643_0008). As a result a Compliance Order is warranted.
(643)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 10, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Adam Dickey

Service Area Office /
Bureau régional de services : Toronto Service Area Office