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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 1, 2019	2019_759502_0006	020053-18, 020196-18, 020385-18, 023320-18, 030554-18, 033602-18	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

JULIENNE NGONLOGA (502), ADAM DICKEY (643)

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): February 19, 20, 21, 22, 25 and 26, 2019.

The following complaints intakes were inspected:
- logs #020053-18 and #020196-18, related to staff to resident alleged abuse,
- log #020385-18, related to plan of care,
- log #023320-18, related to safe and secure home,
- log #030554-18, related to neglect of a resident, and
- log #033602-18, related to multiple care areas.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Nurse Practitioner (NP), Physician (MD), Personal Support Workers (PSW), Housekeeping staff (HSK), residents and family members.

The inspector(s) observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, the home's internal investigation notes, staff schedule and the home's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_525596_0008	502

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Review of a complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) indicated that water was dripping from the air conditioning unit in resident #013's shared room, resulting in a fall with no injury.

Review of resident #013's health care record indicated that the resident had a moderate impairment, a cognitive performance score of three, with a specified diagnosis. The resident ambulates with a walker independently in the room, and is toileted independently with one person assistance as needed.

Review of resident #013's progress notes indicated that on an identified date, resident #013 had a fall due to the wet floor, no injury was noted.

Review of Daily Maintenance log for an identified floor indicated that on two identified dates prior to resident #013's above mentioned fall, registered staff documented that water was leaking form the air conditioning unit. The maintenance staff documented that nothing could be done and it can't be fixed in the action taken column.

In an interview, PSW #120 indicated that they found resident #013 on the floor while conducting the rounds at the beginning of their shift. The PSW indicated that they observed water on the floor and the resident told them that they slipped on that water and fell.

In separate interviews, Housekeeping staff #119, RNs #110 and #118 indicated that water was leaking from the air conditioner installed in an identified room and flowing on the floor toward the washroom, which was also close to resident #013's bed. The staff indicated that the water dripping from the air conditioner was putting the residents in that

room at risk of fall. They notified the maintenance supervisor and they were told that nothing could be done about it. Staff were placing blankets on the window sill and on the floor to contain the water. They checked the blankets regularly to ensure the water was contained and changed them as needed when they were soaked.

RN#118 indicated that on the day mentioned above that the resident had a fall, they conducted a round after the shift report at 2300 hrs, and they noted that the blankets were soaked with water. They changed the blankets and wiped the water on the floor, but they did not know that water had flowed under resident #013's floor mat, and toward the washroom. When resident #013 got up and walked toward the washroom, they slipped and fell. The resident complained of pain during the head to toe assessment.

In an interview with the Administrator, who is also the maintenance lead, they indicated that the air conditioner that was installed in resident #013's room belonged to the resident. For any equipment repair that cannot be fixed by the home's maintenance, the staff of the home should have contacted the family to have the air conditioner repaired or removed.

The Administrator indicated that the blankets to keep the moisture contained were not changed when they were saturated with water. The administrator indicated that any type of fluid on the floor will make the environment unsafe for the resident and a potential risk for falls. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 4th day of March, 2019

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

Original report signed by the inspector.