Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 19, 2019	2019_526645_0008	003484-19, 006184-19, 006309-19, 010719-19	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

DEREGE GEDA (645)

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): July 3, 4, 5, 9, 10 and 12, 2019.

The following critical incidents with Log# 003484-19, #006309-19 and #010719-19 related to falls prevention and management, and a follow up inspection with Log# 006184-19 related to prevention of abuse and neglect, were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers, (PSWs), and Residents.

During the course of the inspection, the inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, staff training records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 19. (1)	CO #001	2019_767643_0007	645

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.

Record review of a Critical Incident System (CIS) report, submitted to the MOHLTC indicated that resident #001 had a fall on an identified date.

Record review of the clinical document on the day of the fall, indicated that resident #001 had a fall and sustained an injury to the identified part of the body. The home completed a post fall assessment, and developed interventions to prevent further falls. The interventions included to keep the call bell within reach and apply an injury protection equipment to the identified part of the resident's body.

During the inspection, resident #001 was observed not wearing the protective equipment as mentioned above and as specified in the plan of care. The plan of care directed staff members to apply the protective equipment on resident #001 during the day.

Interview with nurse manager #100 confirmed that resident #001 was not wearing the equipment as specified in the plan of care. They confirmed that the plan of care directed staff members to apply the equipment to prevent body injuries. They reiterated that staff members are expected to provide care as specified in the plan of care and confirmed that resident #001 did not receive care as specified in the plan. [s. 6. (7)]

2. Record review of a CIS report submitted to the MOHLTC indicated that resident #002 had a fall.

Record review of the clinical records indicated that resident #002 had a fall incident and sustained an injury. The home completed a post fall assessment and developed interventions to prevent further falls. The interventions included to keep the call bell within reach and apply an injury prevention equipment to the identified part of the resident's body to prevent injury.

On an identified date, resident #002 was observed not wearing the protective equipment. The inspector interviewed the primary PSW #103. The PSW confirmed that the resident was not wearing the equipment and stated that the equipment was not available at the time.

Interview with nurse manager #102 confirmed that resident #002 was not wearing the equipment as specified in the plan of care. They indicated that the equipment was available in the storage room. They reiterated that staff members are expected to provide care as specified in the plan of care and confirmed that resident #002 did not receive care as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that when resident #001 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Review of a CIS report submitted to the MOHLTC indicated that resident #001 had a fall in May 2019 and sustained an injury.

Record review of the progress note indicated that the resident also had three different previous fall incidents other than the fall incident identified above.

The resident's plan of care was updated with fall prevention interventions following the May 2019 fall incident. Further record review indicated that the plan of care was not updated, and no new interventions were implemented following the previous three fall incidents indicated above.

Interview with the ADOC and DOC indicated that when a resident has a fall, registered staff are expected to reassess the resident, develop interventions to prevent further falls and update the plan of care. In the event that the resident continues to fall, staff are to develop different approaches to prevent the fall from happening again and modify the plan of care with new interventions. They reiterated that recurring falls are the result of

unmet or ineffective interventions and requires reassessment to prevent further fall incidents and injuries. Both the ADOC and DOC confirmed that registered staff neither used a different approach, nor implemented different interventions to prevent resident #001 from having recurring falls until after the fall incident in May 2019. [s. 6. (11) (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 the care set out in the plan of care was provided to the residents as specified in the plan, and that the resident is reassessed and the plan of care is being revised because the care set out in the plan had not been effective, different approaches were considered, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a fall prevention and intervention plan, based on, at a minimum, an interdisciplinary assessment was included in the plan of care following a fall incident.

Record review of a CIS report submitted to the MOHLTC, indicated that resident #002 had a fall on an identified date and sustained an injury.

Review of the progress note indicated that the resident also had another fall incident prior to the fall incident identified above. A review of the plan of care indicated that there was no fall prevention focus and interventions initiated for the fall incident prior to the identified one.

Review of the SCOTT fall risk assessment tool indicated that the resident was determined to be at "moderate risk" for fall. Further review of the plan of care indicated that the fall prevention plan of care was initiated after the incident of fall identified above and there was no plan of care initiated for the previous fall incident.

Interview with the ADOC and DOC confirmed that fall prevention interventions were not initiated for the fall incident prior to the identified one. The ADOC further indicated that registered staff are expected to initiate a fall prevention plan when a resident is assessed to be moderate risk for fall. The plan of care should include a fall prevention strategy to mitigate falls. [s. 26. (3) 10.]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #001 and #002 were assessed using the home's clinically appropriate assessment instrument called SCOTT Post Fall Assessment tool, following fall incidents.

Review of the home's fall prevention manual called "Falls Prevention Program Manual, INDEX FP-P-20", revised on January 2019, indicated that registered staff are to complete a post fall risk assessment following every fall incident using "SCOTT Post Fall Risk Assessment" tool and develop interventions to mitigate falls.

The following two CIS reports were reviewed by inspector #645.
- Review of a CIS report submitted to MOHLTC indicated that resident #001 had a fall and sustained an injury. Review of the progress note indicated that the resident also had multiple other incident of falls. Further review of the clinical record indicated that SCOTT post fall risk assessment was not completed following the fall incidents indicated above.

- Record review of a CIS report submitted to the MOHLTC indicated that resident #002, had a fall on an identified date and sustained an injury. Review of the progress note indicated that the resident also had another incident of fall prior to the fall incident identified above. Further review of the clinical record indicated that SCOTT post fall risk assessment was not completed following the two above mentioned fall incidents.

Interview with the ADOC and DOC confirmed that SCOTT post fall assessment was not completed following the fall incidents identified above. They reiterated that it is the expectation of the home that registered staffs conduct a SCOTT post fall assessment when a resident has a fall. [s. 49. (2)]

Issued on this 22nd day of July, 2019

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

Original report signed by the inspector.