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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
September 23, 26, 27, 28, October 3 and 4, 2011	2011_026147_0027	Complaint

Licensee/Titulaire
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(s)

Laleh Newell - 147

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector(s) spoke with: Director of care (DOC), Assistance Director of Care (ADOC), Registered staff, resident and family.

H-000908-11 and H-001442-11

******Amended Public Report with Original WN #1 (LTCHA, 2007 S.O. 2007, c.8, s 24(1)1)removed.

During the course of the inspection, the inspector(s): reviewed resident clinical charts and progress notes, reviewed Policy and Procedure related to Critical Incident reporting, Minimal Lift and Prevention of Abuse and neglect.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection. The following action was taken:

4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:
s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings:

1. The home failed to ensure the policy and procedure related to Critical Incidences were complied with.
2. In 2011 an identified resident sustained an injury as a result of staff not using safe and proper transferring techniques when assisting resident.
3. The home failed to complete a written incident report related to the incident as per home's policy and procedure - Critical Incidents.

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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 the home put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:
s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings:

1. The home did not ensure the resident's substitute decision-maker was promptly informed of a serious injury of the resident.
2. In 2011 an identified resident sustained an injury due to staff not using safe and proper transferring techniques when assisting resident.
3. The home did not notify the resident's Power of Attorney for personal care regarding the injury the resident sustained related to the improper transferring by the staff.

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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 all resident's substitute decision maker are promptly notified regarding any serious injury or illness, to be implemented voluntarily.

WN #3: 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:

1. The home did not ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
2. In 2011 an identified resident sustained an injury as a result of staff not using safe and proper transferring techniques when assisting resident.
3. According to the home's documentation and internal incident report, the resident was transferred improperly by an agency psw who was not aware of the correct method of transferring the resident.

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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 all staff use safe transferring and positioning devices to techniques when assisting all residents, to be implemented voluntarily

WN #4: 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 subsections:
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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings:

1. The home failed to the resident was reassessed and the plan of care reviewed and revised when the resident's care needs had changed.
2. An identified resident was admitted to in-patient psychiatric facility for further assessment related to responsive behaviours. The resident's plan of care was not updated to reflect the changes in managing the resident's behaviours as identified when discharged from in-patient psychiatric facility.

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Inspector ID #:	147
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 resident's plan of care is reviewed and revised when the resident's care needs have changed, to be implemented voluntarily.***	

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Jan 13/2012.