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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Sep 03, 2015;	2015_338147_0009 (A1)	H-002269-15	Resident Quality Inspection

Licensee/Titulaire de permis

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 ou des inspecteurs

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Order #004 was corrected from July 15, 2015 to July 15, 2016.

Issued on this 3 day of September 2015 (A1)

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

Original report signed by the inspector.

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 20, 21, 22, 23, 24, 27, 28, 29, 30, May 1 and 4, 2015

Complaints and Critical Incidents completed in conjunctions with this inspection:

H-000786-14, H-001111-14, H-001301-14, H-001751-14, H-001924-15 and H-002413-15

Follow up to Orders completed in conjunction with this inspection:

H-000416-13, H-000480-14, H-000468-14, H-001895-15, H-002185-15 and H-002184-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON), Nurse Managers, Registered staff, Building Services Supervisor, Dietitian, Food Services Manager, Dietary Aides, Personal Support Worker(PSW), Activity Coordinator, Physiotherapist, Resident Service Coordinator, Resident Council President, Residents and Families.

The Inspectors also toured the home, observed the provision of care and services, and reviewed documents including but not limited to: clinical health

records, policies and procedures and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

20 WN(s)
9 VPC(s)
10 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. 101. (4)	CO #012	2014_201167_0005	147
O.Reg 79/10 s. 16.	CO #002	2015_189120_0007	120
O.Reg 79/10 s. 17. (1)	CO #001	2015_189120_0007	120
O.Reg 79/10 s. 69.	CO #001	2014_190159_0023	503
O.Reg 79/10 s. 90. (2)	CO #008	2013_191107_0005	147

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. 6. Plan of care

Specifically failed to comply with the following:

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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

The written plan of care for Resident #108 directed staff to provide the resident with half of a minced sandwich at evening snack. This intervention was initiated in October 2014. Review of progress notes and the Physician's Order Form revealed that on February 2015 the resident's diet texture was changed to puree. Interview with the home's Registered Dietitian (RD) revealed this change was implemented related to an assessment of the resident's preference and intake, and that the minced sandwich at evening snack remained an appropriate intervention for the resident. Interview with PSW staff revealed that the resident no longer was provided the minced sandwich. The home's Food Services Manager (FSM) revealed that when the diet texture was changed to puree, the sandwich was discontinued as a labeled snack by the FSM and a pudding was sent to replace the sandwich, which was being provided during the afternoon snack. Interview with the home's RD and a review of the resident's progress notes revealed that the RD was not aware of this change and therefore the written plan of care was not updated to reflect the change in intervention. The home's FSM and RD did not collaborate with each other in the development and implementation of the plan of care related to resident #108's snacks. [s. 6. (4) (b)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the afternoon snack pass on May 4, 2015 the LTC Inspector observed the following:

A) Resident #402 was provided a cup of coffee and a cookie. The resident's plan of care directed staff to provide the resident with 125 ml jello at afternoon snack related to poor fluid intake.
B) Resident #304 was offered a glass of juice thickened to pudding consistency. The resident refused the beverage. The resident's plan of care directed staff to provide the resident with fluids of a nectar thick consistency.
C) Resident #303 was provided a glass of juice thickened to nectar consistency. The resident's written plan of care directed staff to provide the resident with 118ml great shake plus at afternoon snack to increase caloric intake.

Staff identified to the Inspector who they were providing snacks to and confirmed what they were providing. An interview with the home's Food Service Manager confirmed that the identified residents were not provided the afternoon snack as per their plans of care. [s. 6. (7)]

Additional Required Actions:

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

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 staff and others involved in the different aspects of care of the resident collaborate with each other 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home's policy and procedures Abuse and Neglect dated July 11, 2013 was reviewed and it included: "All staff, volunteers, contractors and affiliated personnel are required: To fulfill their legal obligation to immediately and directly report any incident or alleged incident of abuse or neglect to the MOHLTC.

A. During a record review for resident #104 the progress notes indicated that on an identified date in March 2015 the Recreation staff reported that they witnessed an inappropriate touching by the resident towards another resident. This was reported to the registered staff immediately, however there were no further documented evidence to substantiate any further follow up was conducted by the registered staff related to this incident.
Interview with the DON confirmed that she was aware of this incident, however it was not reported to the MOHLTC as per home's Abuse and Neglect policy and procedure. (147)

B. The record of identified resident #110 was reviewed and progress notes indicated that on on identified date in January 2015 the resident reported to the home's staff that resident #201 was physically abused by a co-resident. The identified resident #110 also called the police department and reported the alleged physical abuse.
The home's record including the Critical Incident report #2656-000006-15 was reviewed and indicated that the incident of alleged physical abuse was not reported to the MOHLTC on for several days after the incident had occurred.

The DON was interviewed and confirmed that the home reported the alleged physical abuse to the MOHLCT several days after the incident had occurred.

The home did not immediately report the alleged physical abuse of resident #201 as per the policy and procedures. (123)

C. During an interview Resident #102 reported to the Long Term Care (LTC) Inspector that a staff member had grabbed the resident's arm leaving a bruise and that this incident had been reported to the home's staff. A review of the resident's progress notes revealed that the resident had a small bruise on their arm and had reported this incident to registered nursing staff. Interview with the home's DON revealed that the DOC was not aware of the allegation and that the Director had not been informed. (503) [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff that provide direct care to residents receive, as a condition of continuing to have contact with residents, training on abuse recognition and prevention annually in accordance with r. 221 (2).

Review of the home's Abuse Prevention and Abuse Decision Tree training documents indicated that 34 of 100 (34%) direct care staff completed the home's training module in 2014. The DON confirmed this and stated that all direct care staff should have completed this training annually. [s. 76. (7) 1.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied is titled "all other homes". Non-compliance related to illumination levels in stairwells, corridors, resident bedrooms and shower areas was previously identified during an inspection completed in April 2013. The Licensee was informed during the previous inspection that they would need to ensure compliance with required illumination levels by taking measurements during evening or night time conditions.

A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in various areas. The meter was held a standard 30 inches above and parallel to the

floor. Resident bedrooms, dining rooms and lounge areas could not be tested due to natural light infiltration. Outdoor conditions were bright during the measuring procedure and compliance with the lighting table would need to be verified by the licensee for the areas not measured during this inspection.

The stairwells lights were not measured during this inspection as the illumination levels appeared dark and the fixtures appeared similar to those previously measured. The levels previously identified were as follows;

East Stairwell

Outside the 3rd floor stairwell door, 0 lux, under the fluorescent light
Outside the 2nd floor stairwell door, 50 lux under the fluorescent light
Outside the 1st floor stairwell door, 0 lux, under the fluorescent light
Zero lux while walking up or down the stairs
2nd and 3rd floor landing - 90 lux

West Stairwell

Outside the 3rd floor stairwell door, 20 lux under the fluorescent light
Outside the 2nd floor stairwell door, 90 lux under the fluorescent light
Outside the 1st floor stairwell door, 20 lux under the fluorescent light
2nd floor landing, 90 lux
3rd floor landing, 150 lux
Zero lux while walking up or down the stairs.

The required level of illumination for stairwells is a continuous consistent lux of 322.92.

The following was verified during this inspection:

First floor corridor (towards dining room) – equipped with semi-flush ceiling mounted fluorescent lights with a clear lens. The fixtures were spaced 12 feet apart and the level of illumination ranged between 75-500 lux. A continuous consistent lux of 215.28 is required.

Third floor corridors (west) – equipped with semi-flush ceiling mounted fluorescent lights with a clear lens spaced 8-12 feet apart. Some of the corridor fluorescent light fixtures were measured at 500 lux directly under the light and 150 lux between

fixtures. A continuous consistent lux of 215.28 is required.

Fourth floor corridor (east) – equipped with fluorescent light fixtures flush with ceiling tiles were spaced 6-8 feet apart ranged from 50-300 lux. A continuous consistent lux of 215.28 is required.

Resident bedrooms – no general room light fixtures available. Each bed was equipped with a wall mounted bed over the head of the bed. Not able to verify illumination levels due to natural light infiltration through the window curtains. The outdoor conditions were very bright at the time of the test. Previous measurements taken in April 2013 on a cloudy day revealed levels of 10 lux in the centre of the room (when over bed lights off).

Resident bathrooms – wall mounted light fixtures over the vanity area provided. Lux levels ranged between 90-150 when measured centrally in the room, depending on the number of light bulbs in the fixture, the type of bulb and age of bulb.

Shower rooms (west) – fourth floor – fluorescent light in shower area (not centrally located in shower area), 190 lux under light and 10 lux under shower head area. The area over the toilet was 160 lux. Third floor shower room was 90 lux centrally in the room, 10-20 lux over the toilet area and 50 lux over the vanity area.

The Administrator did not have any written lighting upgrade plans or schedules in place for the home at the time of the visit but identified that one resident bedroom on third floor was equipped with a light fixture as a trial. [s. 18.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 004

WN #5: 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 use safe transferring and positioning devices or techniques when assisting residents.

A. Review of resident #401's home's internal investigation notes and interview with the registered staff, confirmed that on an identified date in June 2014, the resident was being transported by staff in their wheelchair, when the resident suddenly leaned forward and resulted in the resident falling forward out of the wheelchair. Resident was assessed post fall by the registered staff and sustained injuries.
Review of the home's user manual for the use of the wheelchair, warns that proper positioning is essential for safety and when reaching, leaning or bending forward, these movements will cause a change to the normal balance, the center of gravity and the weight distribution of the wheelchair. It is important to use the front casters as a tool to maintain stability and balance.
Interview with the physiotherapist confirmed that the result of the resident's injuries was due to the staff not using safe transferring techniques by not applying the foot pedals on the wheelchair prior to transporting the resident.

B. On an identified date in April 2015 resident #402 had a witnessed fall during a toileting transfer by two personal support workers (PSW) using a lift. Interview with the DON and review of the home's investigation notes, confirmed that the two PSWs did not use safe technique when assisting the resident with the sit to stand lift by not ensuring that one psw was operating the lift and the other psw guiding and supporting the resident.
The resident was subsequently assessed by the registered staff and had sustained injuries. Resident was then transferred to hospital for further assessment and treatment. [s. 36.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies are developed and implemented to meet the needs of residents who cannot communicate in the language or languages used in the home.

A. Review of the resident #103's plan of care and interview with the staff confirmed the resident's primary language for communication is not the same language used in the home. To communicate with the resident, the resident's care plan directed staff to use gestures, facial expressions and simple words. However, interview with resident #103 with the assistance of an independent translator, stated that the resident frequently is unable to understand the staff when spoke to in English, the resident is able to answer yes or no to their questions, but does not always fully understand the intend of their questions or requests. The resident also states that the staff use hand signs and gestures to communicate with the resident, but there are times where the resident is unable to fully comprehend the meaning of their requests. Through the assistance of the translator, the resident verbalized feeling of frustrations and loneliness due to the language barrier, as the resident is unable to fully communicate their needs to the staff in the home.
Interview with the DON and Administrator confirmed that currently the home does not have any relevant written policies and protocols in place to ensure that strategies are developed and implemented to meet the needs of resident's who cannot communicate in the language used in the home. (147)

B. Review of the resident #107's plan of care and interview with the staff confirmed the resident's primary language for communication is is not the same language used

in the home. However, there were no strategies in the resident's plan of care to direct staff on how to communicate with the resident. Interview with resident #107 with the assistance of an independent translator, stated that they frequently are unable to understand the staff when spoke to in English, the resident is able to answer yes or no to their questions, but does not always fully understand the intend of their questions or requests. The resident also verbalized through the interpreter that due to their current health needs the resident now requires increased assistance with all aspects of their activity of daily living in the morning and at bedtime, however is unable to articulate these needs to the staff due to the language barrier.
Interview with the DON and Administrator confirmed that currently the home does not have any relevant written policies and protocols in place to ensure that strategies are developed and implemented to meet the needs of resident's who cannot communicate in the language used in the home. (147)

C. Resident #111's primary language for communication was not the same language used in the home and the resident's plan of care noted that they spoke and understood little English. To communicate with the resident, the resident's care plan directed staff to encourage non-verbal communication, provide reassurance and patience when communicating, reduce background noise and to ensure adequate lighting and line of sight. An interview with the resident revealed that the resident felt staff were unable to communicate with the resident and that staff treated the resident like a child. Interview with the home's Administrator revealed that the home was unaware of the resident's concerns and acknowledged that different avenues could be looked at to enhance communication and monitor resident's satisfaction when residents do not speak the language of the home. (503) [s. 43.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101 as evidenced by:

The home's policy and procedures Complaints dated July 31, 2013 was reviewed and it did not include: A response that complies with paragraph three provided within 10 business days of the receipt of the complaint and for those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement for receipt of the complaint shall be provided within 10 business days of the receipt of the complaint including the date by which the complaint can reasonably expect a resolution, and a follow-up response that complies with paragraph three shall be provided as soon as possible in the circumstances.

The DON was interviewed and confirmed that the home's policy and procedures Complaints dated July 31, 2013 did not incorporate the requirements set out in section 101 as noted above.

The home's Complaint policy and procedures did not include all the requirements related to providing a response to the complainant within 10 business days. [s. 100.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A. Review of resident #401's home's internal investigation notes and interview with the registered staff, confirmed that on an identified date in June 2014, the resident was being transported by staff into the dining room while in their wheelchair, when the resident suddenly leaned forward. Resident was assessed post fall by the registered staff and sustained injuries and was transferred to hospital for further assessment and treatment.
According to progress notes, resident returned to the home with multiple injuries However, the critical incident was not submitted to the Director until several days later related to the incident which caused an injury that resulted in a significant change in the resident's health condition to resident #401.

B. On an identified date in April 2015 resident #402 had a witnessed fall during a toileting transfer by two personal support workers (PSW) using a lift. Interview with the DON and review of staff interviews indicated that one PSW was operating the lift and the other PSW was standing by the left side of the resident and not supporting the resident during the transfer process.
The resident was subsequently assessed by the registered staff who had sustained injuries. Resident was then transferred to hospital for further assessment and treatment.
However, the critical incident was not submitted to the Director until a few days later related to the incident which caused an injury that resulted in a significant change in the resident's health condition to resident #402. [s. 107. (3.1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that procedures or schedules were in place for routine remedial or preventive maintenance related to indoor furnishings and surfaces such as hand rails, walls, windows, doors, floors, ceilings, furnishings, plumbing fixtures and vanities.

The licensee did not establish a procedure to ensure that vanities, walls, doors and door casings would be maintained and by whom and how. No schedules were in place for review to determine which resident rooms and bathrooms were going to receive wall repairs, painting or laminate repairs. No written records were maintained by the maintenance person as to what rooms had vanities, doors and walls painted or repaired and/or patched and what areas remained to be addressed. No preventive audits had been completed of resident rooms, bathrooms or common areas to determine what if any maintenance issues needed to be addressed. The maintenance program was largely reactive, dependent on staff to report issues when they saw them. In addition, not all of the issues when reported were addressed in a timely manner. A leak was repaired in the kitchen on January 30, 2015 however the ceiling drywall was not replaced and painted until mid April 2015. Previous inspections completed in the home in 2013 and 2014 revealed several bathroom walls that were patched but not sanded or painted and remained in the same condition during this inspection. The maintenance person who was hired two years ago confirmed that he was not involved in any of the patch repairs in several of the

identified bathrooms. The following observations were made during the inspection and no schedules were in place to address the issues;

A) Casings around bathroom entrances were peeled down to the metal in rooms #418, 417, 415, 414, 412, 411, 409, 403, 401.
B) Walls were not finished after patching/plastering in bathrooms #412, 311, 308, 307 and in bathrooms #407, 412 and 215, the exposed dry wall paper was not addressed where the former soap dispensers were removed over a year ago. Walls in bedrooms were primed but not painted and had a heavy amount of scuffing in #319, 205 and 202. Deep gouges noted on wall in bedroom #405, corner damage in bedrooms #401 and 202, damaged wall near window with mouldy appearance in bedroom #212 and hole in wall under vanity in bathroom #206.
C) Wall tiles were missing or badly damaged in the 4th and 3rd floor tub/shower rooms. The maintenance person did not have any spare tiles to replace the damaged tiles. The damage was previously identified during an inspection in April 2014. The Administrator identified that plans were in place to cover the lower 12 inches of wall surface with stainless steel to prevent further damage from wheelchairs and lifts, but no specific date was provided for the installation of the wall protection.
D) Vanities were not in good condition in bathrooms 416, 411, 410, 403, 404, 402, 304, 322. The vanities either had skirting in rough condition where it was cut out to accommodate a new toilet and not finished, skirting that was damaged and rough, laminate that was missing from edges or laminate that was lifting or missing from vanity tops. Non-compliance for poor vanity condition (for the same bathrooms) was previously issued under s. 15(2)(c) of the Long Term Care Homes Act on March 29, 2013.
E) Wooden hand rails located on the 3rd and 1st floors were not in good condition. Large gouges were present on the 3rd floor (near elevator and rooms 312 and 316) which were sharp and could cause skin tears or splintering. A staff member reported that a section of handrail on the 1st floor was a "safety hazard" as a panel (vinyl piece covering gouged areas) had come off on April 23, 2015. The hand rail was in the same condition on April 29, 2015. The vinyl covering the front surface of the rail broke off in one large chunk and had sharp edges, also exposing the Velcro that was used to attach the vinyl to the wood surface, making it difficult to clean.
F) Exhaust grill covers were noted to have been missing in both 2nd and 3rd shower rooms (west) during an inspection conducted in April 2014 and again during this inspection.
G) The flooring material in the 3rd floor east shower room was split along the coved portion of the flooring material. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #10: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, is complied with.

A. The licensee failed to ensure that the home's "Falls Preventions" Policy was complied with.

The home's Falls Prevention: Falls Intervention Risk Management (FIRM) Overview – Index: CPM-C-10, effective date: January 2014, direct staff that for post fall management, the registered staff will assess the resident for injury including range of motion, pain, bruises, laceration, vital signs and neurological assessment as applicable and if necessary the resident should be transferred to hospital for further evaluation.

On an identified date in April 2015 resident #402 had a witnessed fall during a toileting transfer by two personal support workers (PSW) using a lift. Interview with the DON and review of the home's investigation notes, confirmed that the two PSWs transferred the resident from the floor to their wheelchair post fall, prior to having the registered staff assess the resident for any post fall injuries as per the home's post fall procedure. The resident was subsequently assessed by the registered staff while in the wheelchair and was assessed as sustaining injuries. Resident was then transferred to hospital for further assessment and treatment. (147)

B. The licensee failed to ensure that the home's "Complaints" policy was complied with.

The home's policy "Complaints" issued on July 31, 2013, directs staff to document all concerns and complaints on the "Complaint Log" located at each nursing unit. The policy indicates that concerns/complaints include residents' lost personal items. Review of the progress notes for Resident #102 reveal that the resident's glasses were reported missing. An interview with the home's DOC revealed that it was the expectation that all lost personal items would be documented in the "complaint log" and that the resident's missing glasses had not been documented in the log. (503)

C. The licensee failed to ensure that the home's "Nourishment Cart" policy was complied with.

The home's policy "Nourishment Cart", DTY-A-265, effective February 2012, directed staff to include the diet roster list on the nourishment cart when setting up the cart. During the afternoon snack pass on May 4, 2015 on the second and fourth floors LTC inspectors observed that the nourishment carts did not have the diet roster list on them while nourishment was being provided to residents. The policy further directs staff to distribute nourishments as per the nourishment menu and nourishment list. The nourishment menu directed staff to provide residents with pear drink, or an alternative beverage, and a cookie. Resident #305 was observed to be provided two pureed cookies and was not offered a beverage. Interview with the home's Food Services Manager confirmed that the home's "Nourishment Cart" policy was not complied with. (503) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A. During medication observation on April 29, 2015, the Long Term Care (LTC) Inspector observed several discarded medication pouches and one empty medication bottle in the garbage can attached to the medication cart. The medication pouches and bottle were observed to still have residents personal health information clearly written, including the resident's names, medication name and dosage on them without ensuring the information was removed prior to being discarded in the garbage.
Interview with the registered staff confirmed the process is to place the medication pouches after administration in a bowl of water to ensure all personal health information are removed prior to discarding the pouches in the garbage. This did not ensure the residents' rights to promote their personal health information within the meaning of the Personal Health Information Act, 2004 was kept confidential.

B. On April 29, 2015 the LTC inspector was sitting behind the nursing station and found a stack of scrap paper being used by staff which contained numerous residents' personal health information - such as Medication Administration Records, care plans, lab reports and 24 hours shift reports. The stack of paper were reviewed with the registered nurse on the unit, who confirmed that the scrap papers were prepared by the staff for the use on the unit contained personal health information of the resident's on the unit and are to be shredded.
Interview with the Administrator confirmed that the resident's documents with personal health information are not to be used as scrap paper on the units and are to be placed in a bin on the nursing station for shredding by the staff. This did not ensure the residents' rights to promote their personal health information within the meaning of the Personal Health Information Act, 2004 was kept confidential. [s. 3. (1) 11. iv.]

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 following rights of residents are fully respected and promoted to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to non-residential areas were kept locked when they were not being supervised by staff.

A door located on the main floor that led from the long-term care home to a corridor called the "link" and further on to the retirement home (non-residential area) was not directly supervised and was not kept locked. The door was equipped with a magnetic locking system and keypad which was tested several times and noted to be on by-pass on both April 28 and April 29, 2015. The Administrator stated that the doors if opened by a person without keying in a code, alarmed to the second floor nursing station. However, the door was not required to have an alarm and the process did not prohibit a resident from entering into the retirement home. The Administrator confirmed that the door was normally kept unlocked during the day and locked after administrative staff left the building for the day. Administrative staff located at the front desk could not adequately supervise the door while conducting duties such as answering phones, photocopying, speaking to visitors and stepping away from their desks periodically. The staff at the main desk, especially when seated at their desks, were recessed back and away from the corridor with the exit door leading to the "link" and did not have a direct line of vision from their desks to the door that was being used by residents, staff and visitors.

Non-compliance for this issue was previously issued on March 29, 2014. [s. 9. (1) 2.]

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 all doors leading to non-residential areas were kept locked when they were not being supervised by staff, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that uses sound to alert staff, was properly calibrated so that the level of sound is audible to staff.

The audibility of the RSCRS was tested on the fourth floor on April 28, 2015 just prior to the lunch time meal. The nursing stations located on floors two to four were equipped with an audio speaker that emitted sound only at the nurse's stations. The sound was very loud and disturbing at the nurse's stations and not very audible the further one moved away from the stations. When an activation station was tested in the fourth floor dining room, the alert or sound from the audio speaker could not be heard inside of the dining room or just outside of the dining room. Competing sounds from residents' televisions and people talking drowned out the alert. Some staff confirmed that they could hear the alert on the third floor (sound was more intense) and others identified that it was disturbing for staff and residents when near the nurse's stations. Discussion was held with the Administrator regarding the options to calibrate the sound equally throughout the floors so that it is not overly loud in one area and inaudible in another. [s. 17. (1) (g)]

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 was equipped with a resident-staff communication and response system (RSCRS) that uses sound to alert staff, was properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions

A. The LTC Inspectors observed on April 20 and 28, 2015 that the Raised Toilet Seat (RTS) with arms in room #307 to be loose and not fitting properly on the toilet. Interview with the Registered Practical Nurse (RPN) on the unit confirmed that the RTS was loose and required to be tightened and cleaned by the maintenance staff. Review of the manufacturers" instruction for the raised toilet seat with arms provided by the home, confirmed that the staff are to check for secure fit routinely before using the product and if the product will not fit properly, or cannot be tightened securely, it is recommended that the product be discontinued for usage.

B. During medication observation on the 3rd floor on April 29, 2015, the LTC Inspector observed the registered staff utilizing First Crush machine for crushing medication for residents. It was observed during several medication administrations that the registered staff were not using the First Crush machine between usage as per manufactures instruction to reduce cross contamination of medications.
As per First Crush manufacturers' instructions, staff are required to use a top and bottom cup for every crush. During the medication observation the registered staff administrating medication was not using a top and bottom cup after each medication and was not observed to clean the machine after each use either. After repeated use, the First Crush machine had accumulated a "cocktail" of residual of several different medications being administered to each resident.
Interview with the DON and Administrator confirmed that the registered staff are to use a top and bottom cup for each medication administration to reduce any cross contamination of medication for any residents. [s. 23.]

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 that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The long term care home failed to ensure that when staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident that these aides are appropriate for the resident based on the resident's condition.

Resident #105 required a wheelchair for locomotion. The resident was observed to be seated in two different wheelchairs during the inspection. One wheelchair was labeled for the resident, the second was labeled as loaner provided by the home. On May 4, 2015 the resident was observed to be seated in the loaner wheelchair in a reclined position. A review of the resident's clinical record found that the resident had not been assessed to determine whether the resident required a new chair and whether the loaner chair was appropriate for the resident. Interview with the home's DON revealed that the staff provided the loaner chair to the resident related to a concern about the resident leaning forward in their wheelchair. The DON further indicated the staff should have referred the resident to physiotherapy for assessment of the appropriateness of each of the chairs and to evaluate pressure off-loading. [s. 30. (1) 2.]

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 when staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident that these aides are appropriate for the resident based on the resident's condition, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

Resident #104's clinical chart was reviewed and progress notes indicated that on an identified date in March 2015 the Recreation staff reported that they witnessed an inappropriate touching by the resident towards another resident. This was reported to the registered staff immediately; however there was no further documented evidence to substantiate any further follow up was conducted by the registered staff related to this incident.
Review of the home's policy – Responsive Behaviours- Responsive Behaviours Program Overview – Index: SP-B-10 – Effective Date: January 2014 – directs staff to identify the causes and triggers for Responsive Behaviours such as physical sexual advances and socially inappropriate or disruptive actions and to develop strategies for prevention and conduct a more in depth interdisciplinary assessment and collaboratively problem solve for possible solutions. The registered staff are to also ensure these interdisciplinary goals and strategies are included in the resident's plan of care based on assessment findings.
Review of the resident's plan of care and interview with the DON confirmed that the resident was not assessed by the registered staff after the incident through any means to ensure steps were taken to minimize any potential harmful interaction and to identify factors that could potentially trigger such altercations by this resident in the future. [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee convened semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council as evidenced by:
The home currently does not have a Family Council. The Administrator was interviewed and confirmed that during the past year the home did not convene semi-annual meetings to advise residents' families and persons of importance to residents of their rights to establish a Family Council.

The home did not hold semi-annual meetings to inform residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (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 licensee convened semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are implemented for the cleaning of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Observations of resident #105's wheelchair made on April 24, 27, 29 and 30, 2015 found the wheelchair to be unclean with visible debris. A review of the "Tyndall Seniors Villages –HCA/PSW Special Assignment Sheet" revealed that the wheelchair was scheduled to be cleaned on Tuesdays and outlined that it was the expectation and responsibility of each assigned staff member to ensure that resident chairs are routinely wiped. Interview with the home's DOC confirmed that the wheelchair was unclean on April 30 and that the chair cleaning procedure had not been implemented. [s. 87. (2) (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 procedures are implemented for the cleaning of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, to be implemented voluntarily.

WN #19: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Resident #111 required total assistance to transfer into and out of bed. The resident revealed in an interview that they are not given a choice as to when they are assisted out of bed in the morning. Interviews with registered nursing staff and PSWs revealed that the staff were unaware of any specific sleep patterns or preferences for the resident. A review of the resident's care plan found that sleep patterns and preferences were not identified for the resident. An interview with the home's DON confirmed that the care plan was not based on an assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment as evidenced by:

On an identified date in April 2015 resident #113 was observed to have a skin tear which was covered with a clear dressing. The resident's record was reviewed and it did not include an assessment by the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The registered nursing staff member was interviewed and confirmed that there was no documentation found in the record of resident #113 of an assessment of the skin tear by a registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.
The home's policy and procedures Skin and Wound Care Program Implementation dated February 2012 was reviewed and included: "The Initial and Ongoing Wound Assessment is implemented when a Resident has any open skin involving the dermal layer and deeper (including surgical wounds), Skin Tears will be assessed using the skin Tear (s) Assessment (Initial and Ongoing). One assessment is completed per wound. Skin Tear Assessment allows for multiple skin tears to be recorded per incident. The treatment regimen is also recorded on the Treatment Administration Record (TAR)."

The home did not ensure that resident #113 who had a skin tear was assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Issued on this 3 day of September 2015 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2015_338147_0009 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-002269-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 03, 2015;(A1)

Licensee / Titulaire de permis : TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3

LTC Home / Foyer de SLD : TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3

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

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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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patricia Bedord

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To TYNDALL NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_201167_0005, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance that includes, but is not limited to, ensuring:
A) All care set out in the plan of care is provided to residents as specified in the plan, related to diet orders and interventions at snack service,
B) All staff involved in the provision of snacks receive training related to the procedures for snack provision and the home's "Nourishment Cart" policy,
C) Procedures and schedules for monitoring adherence to care plans.

The plan to be submitted by June 12, 2015 via Email to Laura.Brown-Huesken@ontario.ca.

Grounds / Motifs :

1. Previously served as a CO on May 28, 2013, July 31, 2013, and April 8, 2014.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During the afternoon snack pass on May 4, 2015 the LTC Inspector observed the following:

A) Resident #402 was provided a cup of coffee and a cookie. The resident's plan of care directed staff to provide the resident with 125 ml jello at afternoon snack related to poor fluid intake.
B) Resident #304 was offered a glass of juice thickened to pudding consistency. The resident refused the beverage. The resident's plan of care directed staff to provide the resident with fluids of a nectar thick consistency.
C) Resident #303 was provided a glass of juice thickened to nectar consistency. The resident's written plan of care directed staff to provide the resident with 118ml great shake plus at afternoon snack to increase caloric intake.

Staff identified to the Inspector who they were providing snacks to and confirmed what they were providing. An interview with the home's Food Service Manager confirmed that the identified residents were not provided the afternoon snack as per their plans of care. (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 03, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

The home complies with all aspects of Abuse and Neglect policy, by ensuring all staff, volunteers, contractors and affiliated personnel are required: To fulfill their legal obligation to immediately and directly report any incident or alleged incident of abuse or neglect to the MOHLTC

The plan to be submitted by June 12, 2015 via Email to laleh.newell@ontario.ca

Grounds / Motifs :

1. Previously issued as CO on March 21, 2013

The licensee failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home's policy and procedures Abuse and Neglect dated July 11, 2013 was reviewed and it included: "All staff, volunteers, contractors and affiliated personnel are required: To fulfill their legal obligation to immediately and directly report any incident or alleged incident of abuse or neglect to the MOHLTC.

A. During a record review for resident #104 the progress notes indicated that on an identified date in March 2015 the Recreation staff reported that they witnessed an inappropriate touching by the resident towards another resident. This was reported to the registered staff immediately, however there are no further documented evidence to substantiate any further follow up was conducted by the registered staff related to this incident.
Interview with the DON confirmed that she was aware of this incident, however it was not reported to the MOHLTC as per home's Abuse and Neglect policy and procedure. (147)

B. The record of identified resident #110 was reviewed and progress notes indicated that on on identified date in January 2015 the resident reported to the home's staff that resident #201 was physically abused by a co-resident. The identified resident #110 also called the police department and reported the alleged physical abuse. The home's record including the Critical Incident report #2656-000006-15 was reviewed and indicated that the incident of alleged physical abuse was not reported to the MOHLTC on for several days after the incident had occurred.

The DON was interviewed and confirmed that the home reported the alleged physical abuse to the MOHLCT several days after the incident had occurred.

The home did not immediately report the alleged physical abuse of resident #201 as per the policy and procedures. (123)

C. During an interview Resident #102 reported to the Long Term Care (LTC) Inspector that a staff member had grabbed the resident's arm leaving a bruise and that this incident had been reported to the home's staff. A review of the resident's progress notes revealed that the resident had a small bruise on their arm and had reported this incident to registered nursing staff. Interview with the home's DOC revealed that the DOC was not aware of the allegation and that the Director had not been informed. (503) (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 24, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall ensure all staff that provide direct care to residents receive, as a condition of continuing to have contact with residents, training on abuse recognition and prevention annually in accordance with r. 221 (2).

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Grounds / Motifs :

1. Previously issued as VPC on March 21, 2013

The licensee failed to ensure that all staff that provide direct care to residents receive, as a condition of continuing to have contact with residents, training on abuse recognition and prevention annually in accordance with r. 221 (2).

Review of the home's Abuse Prevention and Abuse Decision Tree training documents indicated that 34 of 100 (34%) direct care staff completed the home's training module in 2014. The DOC confirmed this and stated that all direct care staff should have completed this training annually. (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jun 26, 2015

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Order / Ordre :

The licensee shall prepare, submit and implement a plan that at a minimum includes the areas of the home that require illumination level upgrades, the time lines for the installation of fixtures or upgrade of illumination levels for the various areas and who will be involved in completing the upgrades or installation of lighting fixtures.

The plan shall be submitted to Bernadette.susnik@ontario.ca by June 30, 2015. The plan shall be implemented by July 15, 2016.

Grounds / Motifs :

1. The licensee did not ensure that the lighting requirements set out in the lighting

table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that applied is titled "all other homes". Non-compliance related to illumination levels in stairwells, corridors, resident bedrooms and shower areas was previously identified during an inspection completed in April 2013. The Licensee was informed during the previous inspection that they would need to ensure compliance with required illumination levels by taking measurements during evening or night time conditions.

A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in various areas. The meter was held a standard 30 inches above and parallel to the floor. Resident bedrooms, dining rooms and lounge areas could not be tested due to natural light infiltration. Outdoor conditions were bright during the measuring procedure and compliance with the lighting table would need to be verified by the licensee for the areas not measured during this inspection.

The stairwells lights were not measured during this inspection as the illumination levels appeared dark and the fixtures appeared similar to those previously measured. The levels previously identified were as follows;

East Stairwell

Outside the 3rd floor stairwell door, 0 lux, under the fluorescent light
Outside the 2nd floor stairwell door, 50 lux under the fluorescent light
Outside the 1st floor stairwell door, 0 lux, under the fluorescent light
Zero lux while walking up or down the stairs
2nd and 3rd floor landing - 90 lux

West Stairwell

Outside the 3rd floor stairwell door, 20 lux under the fluorescent light
Outside the 2nd floor stairwell door, 90 lux under the fluorescent light
Outside the 1st floor stairwell door, 20 lux under the fluorescent light
2nd floor landing, 90 lux
3rd floor landing, 150 lux
Zero lux while walking up or down the stairs.

The required level of illumination for stairwells is a continuous consistent lux of

322.92.

The following was verified during this inspection:

First floor corridor (towards dining room) – equipped with semi-flush ceiling mounted fluorescent lights with a clear lens. The fixtures were spaced 12 feet apart and the level of illumination ranged between 75-500 lux. A continuous consistent lux of 215.28 is required.

Third floor corridors (west) – equipped with semi-flush ceiling mounted fluorescent lights with a clear lens spaced 8-12 feet apart. Some of the corridor fluorescent light fixtures were measured at 500 lux directly under the light and 150 lux between fixtures. A continuous consistent lux of 215.28 is required.

Fourth floor corridor (east) – equipped with fluorescent light fixtures flush with ceiling tiles were spaced 6-8 feet apart ranged from 50-300 lux. A continuous consistent lux of 215.28 is required.

Resident bedrooms – no general room light fixtures available. Each bed was equipped with a wall mounted bed over the head of the bed. Not able to verify illumination levels due to natural light infiltration through the window curtains. The outdoor conditions were very bright at the time of the test. Previous measurements taken in April 2013 on a cloudy day revealed levels of 10 lux in the centre of the room (when over bed lights off).

Resident bathrooms – wall mounted light fixtures over the vanity area provided. Lux levels ranged between 90-150 when measured centrally in the room, depending on the number of light bulbs in the fixture, the type of bulb and age of bulb.

Shower rooms (west) – fourth floor – fluorescent light in shower area (not centrally located in shower area), 190 lux under light and 10 lux under shower head area. The area over the toilet was 160 lux. Third floor shower room was 90 lux centrally in the room, 10-20 lux over the toilet area and 50 lux over the vanity area.

The Administrator did not have any written lighting upgrade plans or schedules in place for the home at the time of the visit but identified that one resident bedroom on third floor was equipped with a light fixture as a trial.
(120)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 15, 2016(A1)

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

1. All staff use safe transferring and positioning devices or techniques when assisting resident while transporting residents in wheelchairs and using the sit to stand lifts while transferring residents.

The plan to be submitted by June 12, 2015 via Email to laleh.newell@ontario.ca

Grounds / Motifs :

1. Previously issued as VPC on March 21, 2013

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

A. Review of resident #401's home's internal investigation notes and interview with the registered staff, confirmed that on an identified date in June 2014, the resident was being transported by staff in their wheelchair, when the resident suddenly leaned forward and resulted in the resident falling forward out of the wheelchair. Resident was assessed post fall by the registered staff and sustained injuries.
Review of the home's user manual for the use of the wheelchair, warns that proper positioning is essential for safety and when reaching, leaning or bending forward, these movements will cause a change to the normal balance, the center of gravity and the weight distribution of the wheelchair. It is important to use the front casters as a tool to maintain stability and balance.
Interview with the physiotherapist confirmed that the result of the resident's injuries was due to the staff not using safe transferring techniques by not applying the foot pedals on the wheelchair prior to transporting the resident.

B. On an identified date in April 2015 resident #402 had a witnessed fall during a toileting transfer by two personal support workers (PSW) using a lift. Interview with the DON and review of the home's investigation notes, confirmed that the two PSWs did not use safe technique when assisting the resident with the sit to stand lift by not ensuring that one psw was operating the lift and the other psw guiding and supporting the resident.
The resident was subsequently assessed by the registered staff and had sustained injuries. Resident was then transferred to hospital for further assessment and treatment. (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jun 30, 2015

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

1. The home is to ensure policy and procedures are developed and implemented in the home for staff to meet the needs of residents who cannot communicate in the language or languages used in the home.
2. The home is to ensure that strategies are developed and implemented to meet the needs for resident #103, #107 and #111 who cannot communicate in the language used in the home.

The plan to be submitted by June 12, 2015 via Email to laleh.newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that strategies are developed and implemented to meet the needs of residents who cannot communicate in the language or languages used in the home.

A. Review of the resident #103's plan of care and interview with the staff confirmed the resident's primary language for communication is not the same language used in the home. To communicate with the resident, the resident's care plan directed staff to use gestures, facial expressions and simple words. However, interview with resident #103 with the assistance of an independent translator, stated that the resident frequently is unable to understand the staff when spoke to in English, the resident is able to answer yes or no to their questions, but does not always fully understand the intend of their questions or requests. The resident also states that the staff use hand signs and gestures to communicate with the resident, but there are times where the resident is unable to fully comprehend the meaning of their requests. Through the assistance of the translator, the resident verbalized feeling of frustrations and loneliness due to the language barrier, as the resident is unable to fully communicate their needs to the staff in the home.
Interview with the DON and Administrator confirmed that currently the home does not have any relevant written policies and protocols in place to ensure that strategies are developed and implemented to meet the needs of resident's who cannot communicate in the language used in the home. (147)

B. Review of the resident #107's plan of care and interview with the staff confirmed the resident's primary language for communication is is not the same language used in the home. However, there were no strategies in the resident's plan of care to direct staff on how to communicate with the resident. Interview with resident #107 with the assistance of an independent translator, stated that they frequently are unable to understand the staff when spoke to in English, the resident is able to answer yes or no to their questions, but does not always fully understand the intend of their questions or requests. The resident also verbalized through the interpreter that due to their current health needs the resident now requires increased assistance with all aspects of their activity of daily living in the morning and at bedtime, however is unable to articulate these needs to the staff due to the language barrier.
Interview with the DON and Administrator confirmed that currently the home does not have any relevant written policies and protocols in place to ensure that strategies are developed and implemented to meet the needs of resident's who cannot communicate in the language used in the home. (147)

C. Resident #111's primary language for communication was not the same language used in the home and the resident's plan of care noted that they spoke and understood little English. To communicate with the resident, the resident's care plan directed staff to encourage non-verbal communication, provide reassurance and

patience when communicating, reduce background noise and to ensure adequate lighting and line of sight. An interview with the resident revealed that the resident felt staff were unable to communicate with the resident and that staff treated the resident like a child. Interview with the home's Administrator revealed that the home was unaware of the resident's concerns and acknowledged that different avenues could be looked at to enhance communication and monitor resident's satisfaction when residents do not speak the language of the home. (503) (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 31, 2015

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

The home's written procedures for dealing with complaints required under section 21 of the Act incorporate the requirements set out in section 101 of the act. Specifically, the home is to incorporate the requirements included in section 101. (1)(2) and (3) of the Regulations into the Complaints policy.

The plan to be submitted by June 12, 2015 via Email to laleh.newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101 as evidenced by:

The home's policy and procedures Complaints dated July 31, 2013 was reviewed and it did not include: A response that complies with paragraph three provided within 10 business days of the receipt of the complaint and for those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement for receipt of the complaint shall be provided within 10 business days of the receipt of the complaint including the date by which the complaint can reasonably expect a resolution, and a follow-up response that complies with paragraph three shall be provided as soon as possible in the circumstances.

The DOC was interviewed and confirmed that the home's policy and procedures Complaints dated July 31, 2013 did not incorporate the requirements set out in section 101 as noted above.

The home's Complaint policy and procedures did not include all the requirements related to providing a response to the complainant within 10 business days. (123)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Jul 31, 2015

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

The plan to be submitted by June 12, 2015 via Email to laleh.newell@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall, (a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and (b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

A. Review of resident #401's home's internal investigation notes and interview with the registered staff, confirmed that on an identified date in June 2014, the resident was being transported by staff into the dining room while in their wheelchair, when the resident suddenly leaned forward. Resident was assessed post fall by the registered staff and sustained injuries and was transferred to hospital for further assessment and treatment.
According to progress notes, resident returned to the home with multiple injuries However, the critical incident was not submitted to the Director until several days later related to the incident which caused an injury that resulted in a significant change in the resident's health condition to resident #401.

B. On an identified date in April 2015 resident #402 had a witnessed fall during a toileting transfer by two personal support workers (PSW) using a lift. Interview with the DON and review of staff interviews indicated that one PSW was operating the lift and the other PSW was standing by the left side of the resident and not supporting the resident during the transfer process.
The resident was subsequently assessed by the registered staff who had sustained injuries. Resident was then transferred to hospital for further assessment and treatment.
However, the critical incident was not submitted to the Director until a few days later related to the incident which caused an injury that resulted in a significant change in the resident's health condition to resident #402. (147)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 17, 2015

Order # /
Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall complete the following:

1. Develop maintenance procedures for internal furnishings, internal surfaces (walls, floors, ceilings, doors), plumbing fixtures such as toilets, sinks, faucets, internal lighting fixtures, windows, beds and other interior components. The procedures shall identify who will monitor the fixtures, surfaces, furnishings or components, the frequency of monitoring and how they will be monitored, the condition expectations, the course of action to be taken when surfaces, equipment, fixtures, components are not in the expected state of repair and required follow up options.
2. Complete a maintenance audit in accordance with the established maintenance procedures of all resident rooms, ensuite washrooms, common washrooms, common spaces, dining rooms and tub/shower rooms and document the findings.
3. Establish a schedule (time frames) and the person responsible to address the maintenance issues identified during the audit along with the issues identified in the grounds below and submit the schedule to the Inspector by July 30, 2015.

Grounds / Motifs :

1. The licensee did not ensure that procedures or schedules were in place for routine remedial or preventive maintenance related to indoor furnishings and surfaces such as hand rails, walls, windows, doors, floors, ceilings, furnishings, plumbing fixtures and vanities.

The licensee did not establish a procedure to ensure that vanities, walls, doors and door casings would be maintained and by whom and how. No schedules were in place for review to determine which resident rooms and bathrooms were going to receive wall repairs, painting or laminate repairs. No written records were maintained by the maintenance person as to what rooms had vanities, doors and walls painted or repaired and/or patched and what areas remained to be addressed. No preventive audits had been completed of resident rooms, bathrooms or common areas to determine what if any maintenance issues needed to be addressed. The maintenance program was largely reactive, dependent on staff to report issues when they saw them. In addition, not all of the issues when reported were addressed in a timely manner. A leak was repaired in the kitchen on January 30, 2015 however the ceiling drywall was not replaced and painted until mid April 2015. Previous

inspections completed in the home in 2013 and 2014 revealed several bathroom walls that were patched but not sanded or painted and remained in the same condition during this inspection. The maintenance person who was hired two years ago confirmed that he was not involved in any of the patch repairs in several of the identified bathrooms. The following observations were made during the inspection and no schedules were in place to address the issues;

A) Casings around bathroom entrances were peeled down to the metal in rooms #418, 417, 415, 414, 412, 411, 409, 403, 401.
B) Walls were not finished after patching/plastering in bathrooms #412, 311, 308, 307 and in bathrooms #407, 412 and 215, the exposed dry wall paper was not addressed where the former soap dispensers were removed over a year ago. Walls in bedrooms were primed but not painted and had a heavy amount of scuffing in #319, 205 and 202. Deep gouges noted on wall in bedroom #405, corner damage in bedrooms #401 and 202, damaged wall near window with mouldy appearance in bedroom #212 and hole in wall under vanity in bathroom #206.
C) Wall tiles were missing or badly damaged in the 4th and 3rd floor tub/shower rooms. The maintenance person did not have any spare tiles to replace the damaged tiles. The damage was previously identified during an inspection in April 2014. The Administrator identified that plans were in place to cover the lower 12 inches of wall surface with stainless steel to prevent further damage from wheelchairs and lifts, but no specific date was provided for the installation of the wall protection.
D) Vanities were not in good condition in bathrooms 416, 411, 410, 403, 404, 402, 304, 322. The vanities either had skirting in rough condition where it was cut out to accommodate a new toilet and not finished, skirting that was damaged and rough, laminate that was missing from edges or laminate that was lifting or missing from vanity tops. Non-compliance for poor vanity condition (for the same bathrooms) was previously issued under s. 15(2)(c) of the Long Term Care Homes Act on March 29, 2013.
E) Wooden hand rails located on the 3rd and 1st floors were not in good condition. Large gouges were present on the 3rd floor (near elevator and rooms 312 and 316) which were sharp and could cause skin tears or splintering. A staff member reported that a section of handrail on the 1st floor was a "safety hazard" as a panel (vinyl piece covering gouged areas) had come off on April 23, 2015. The hand rail was in the same condition on April 29, 2015. The vinyl covering the front surface of the rail broke off in one large chunk and had sharp edges, also exposing the Velcro that was used to attach the vinyl to the wood surface, making it difficult to clean.

F) Exhaust grill covers were noted to have been missing in both 2nd and 3rd shower rooms (west) during an inspection conducted in April 2014 and again during this inspection.
G) The flooring material in the 3rd floor east shower room was split along the coved portion of the flooring material.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Sep 30, 2015

Order # /
Ordre no : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that:

The home fully complies with all aspects of the following policy and procedures:
- Falls Policy
- Complaint Policy
- Nourishment Cart Policy

The plan to be submitted by June 12, 2015 via Email to laleh.newell@ontario.ca

Grounds / Motifs :

1. Previously issued as a CO on February 4, 2014 and March 21, 2013

The licensee has failed to ensure that 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, is complied with.

A. The licensee failed to ensure that the home's "Falls Preventions" Policy was complied with.

The home's Falls Prevention: Falls Intervention Risk Management (FIRM) Overview – Index: CPM-C-10, effective date: January 2014, direct staff that for post fall management, the registered staff will assess the resident for injury including range of motion, pain, bruises, laceration, vital signs and neurological assessment as applicable and if necessary the resident should be transferred to hospital for further evaluation.

On an identified date in April 2015 resident #402 had a witnessed fall during a toileting transfer by two personal support workers (PSW) using a lift. Interview with the DON and review of the home's investigation notes, confirmed that the two PSWs transferred the resident from the floor to their wheelchair post fall, prior to having the registered staff assess the resident for any post fall injuries as per the home's post fall procedure. The resident was subsequently assessed by the registered staff while

in the wheelchair and was assessed as sustaining injuries. Resident was then transferred to hospital for further assessment and treatment. (147)

B. The licensee failed to ensure that the home's "Complaints" policy was complied with.

The home's policy "Complaints" issued on July 31, 2013, directs staff to document all concerns and complaints on the "Complaint Log" located at each nursing unit. The policy indicates that concerns/complaints include residents' lost personal items. Review of the progress notes for Resident #102 reveal that the resident's glasses were reported missing. An interview with the home's DON revealed that it was the expectation that all lost personal items would be documented in the "complaint log" and that the resident's missing glasses had not been documented in the log. (503)

C. The licensee failed to ensure that the home's "Nourishment Cart" policy was complied with.

The home's policy "Nourishment Cart", DTY-A-265, effective February 2012, directed staff to include the diet roster list on the nourishment cart when setting up the cart. During the afternoon snack pass on May 4, 2015 on the second and fourth floors LTC inspectors observed that the nourishment carts did not have the diet roster list on them while nourishment was being provided to residents. The policy further directs staff to distribute nourishments as per the nourishment menu and nourishment list. The nourishment menu directed staff to provide residents with pear drink, or an alternative beverage, and a cookie. Resident #305 was observed to be provided two pureed cookies and was not offered a beverage. Interview with the home's Food Services Manager confirmed that the home's "Nourishment Cart" policy was not complied with. (503) (147)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 17, 2015

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

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3 day of September 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A1)

Service Area Office /
Bureau régional de services : Hamilton