Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2020	2020_751649_0025	022430-20, 022965-20	Complaint

Licensee/Titulaire de permis

Tyndall Seniors Village Inc.
108 Jensen Road London ON N5V 5A4

Long-Term Care Home/Foyer de soins de longue durée

Tyndall Nursing Home
1060 Eglinton Avenue East Mississauga ON L4W 1K3

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 18, 19, 20, off-site on November 23, 24, 25, 26, and 27, 2020.

The following intakes were completed during this Complaint Inspection:
Log #022430-20 related to an outbreak in the home.
Log #022965-20 related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Director of Recreation, Nurse Practitioners (NPs), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Recreation Aides, Housekeeper, and residents.

During the course of the inspection the inspector reviewed residents' health records, conducted observations related to the home's care processes, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a between-meal morning beverage two days in November 2020.

Residents on one of the home areas were not offered their morning snack beverage two days in November 2020, due to the home being significantly short staffed. This was confirmed with staff who were working on the home area on the above mentioned dates.

Sources: staffing schedules, DOC, and other staff interviews. [s. 71. (3) (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 each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents on one of the home areas, two days in November 2020, in accordance with the directions for use specified by the prescriber.

The inspector observed and was informed that there was no nurse available on one of the residents' home areas, two days in November 2020 to administer residents' medications. This led to residents 0700 and 0800 hours medications being administered several hours after their scheduled time.

The DOC and a nurse both acknowledged that medications were not administered to residents on one of the home areas in accordance with the directions for use specified by the prescriber and were administered late.

Sources: Inspector #649's observations two days in November 2020, of a home area, record review of residents' electronic-medication administration records (e-MAR), interviews with DOC, and other staff. [s. 131. (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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

The following observations were made by Inspector #649 related to the home's infection prevention and control program (IPAC).

Observations made on November 18, 2020:
-A Housekeeper was observed wearing three masks and a face shield. The same housekeeper was later observed inside a resident's room without a face shield.
-No outbreak signs were posted on any of the residents' home areas (2nd, 3rd, and 4th floors) indicating that the home was in a COVID-19 (Coronavirus) outbreak or contact/ droplet precautions in place.
-Donning and doffing signs were not observed at the affected residents' rooms; donning and doffing signs were observed at the nursing station on each home area.
-A Recreation Aide removed a food tray from a resident's room, touched the garbage bin, did not performed hand hygiene, and served a beverage to a resident in another room.
-Personal protective equipment (PPE) and supplies were not readily available at approximately nine affected residents' rooms on one of the home areas.
-No droplet/ contact precaution signs were available on 12 affected resident room doors on two of the resident's home areas.
-A nurse and two PSWs were observed wearing two masks.
-A PSW was observed going into several resident rooms offering beverages without changing PPE in between affected residents.

Observations made on November 19, 2020:
-A resident was observed sitting outside a room in their mobility aide exhibiting a responsive behaviour, wiping their mouth with their hands and touching the railing.
-One resident was repositioned by a nurse and PSW, and neither staff changed their PPE after coming into contact with the affected resident. The PSW returned to serving residents their meal trays.
-Most of the residents in the east hallway on one of the home areas were observed sitting outside of their rooms in preparation for the upcoming meal, while their rooms were being cleaned. None of the residents were observed wearing masks and socially distancing.
-A PSW staff placed a meal tray they brought from a resident's room onto the clean cart with unserved meals. A nurse observed this immediately and brought it to the PSW's attention.

Observations made on November 20, 2020:
-A PSW (agency staff) went into several resident's rooms serving residents' snacks, and

did not perform hand hygiene. This was brought to the PSW's attention by the inspector.
-Another PSW (agency staff) went into a resident's room, then came out touched the garbage bin, served a hot beverage to resident in another room, and did not perform hand hygiene. This was brought to the PSW's attention by the inspector.

The DOC was informed of the above mentioned observations and acknowledged the concerns.

Sources: Inspector #649's observations on November 18, 19, and 20, 2020, interview with DOC, and other staff. [s. 229. (4)]

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 ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 22nd day of December, 2020

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

Original report signed by the inspector.