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
Jun 17, 2021	2021_891649_0012	020767-20, 008005-21, 009345-21	Critical Incident System

Licensee/Titulaire de permis

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

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

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

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 9, 10, 11, 12 (off-site), and 15, 2021.

The following Critical Incident System (CIS) intakes were completed during this CIS inspection:
Log #020767-20, CIS #2656-000010-20 related to obtaining and keeping drugs,
Log #008005-21, CIS #2656-000003-21 related to falls prevention and management, and
Log #009345-21, CIS #2656-000005-21 related to Residents' Bill of Rights.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC)/Infection Prevention and Management (IPAC) Lead, Environmental Services Manager (ESM), Registered Nurses (RNs)/Nurse Manager (NM), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Care Assistant, Housekeeper, and residents.

During the course of the inspection the inspector observed staff to resident interactions, conducted resident observations, reviewed residents' clinical records, staffing schedules, air temperature requirements, and observed Infection Prevention and Control Practices (IPAC).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

An observation was made by Inspector #649 related to a resident's right to privacy. The inspector was walking pass the tub/shower room when they observed the door wide open. The Personal Support Worker (PSW) and resident were both visible because the privacy curtain was not completely closed. The PSW had just started to remove the resident's clothing when the inspector walked pass, and immediately called out to the PSW to please stop so as not to expose the resident.

The PSW acknowledged that they made a mistake and stated it would not happen again. This observation was brought to the Director of Care's (DOC) attention.

Sources: observation made by Inspector #649 and interview with the PSW and other staff. [s. 3. (1) 8.]

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: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in one resident common area on every floor of the home, which may include a lounge, dining area or corridor.

The home's Temperature & Humidex Record Tracking Sheet for May 15 through June 9, 2021, were reviewed. They indicated that the temperature was not being measured and documented at a minimum of one resident common area on every floor. The home's Temperature & Humidex Recording Tracking Sheet indicated for May 2021, that the temperature was recorded in the resident's rooms, main dining room and kitchen, and for June 2021, in the resident's rooms, kitchen, main dining room, main lounge, activity room, and laundry. No temperature was being measured or documented in the resident's common areas on the three floors.

The gap in the home's practice was brought to the DOC's attention who acknowledged that the temperature was not being measured or documented in the common areas on the three floors.

Sources: review of the home's Temperature & Humidex Record Tracking Sheet for May 15 through June 9, 2021, for all areas, interview with the DOC and other staff. [s. 21. (2) 2.]

2. The licensee has failed to ensure that the temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The home's Temperature & Humidex Record Tracking Sheet for May 15 through June 9, 2021, were reviewed. They indicated that the temperature was not measured or documented at a frequency of once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in the Long-Term Care (LTC) home.

The home's Temperature & Humidex Recording Tracking Sheet indicated for May 2021, that the temperature was recorded at 1000 and 1500 hours in resident's rooms, at 1000, 1200, 1500, and 1700 hours in the main dining room, and at 1000, 1200, 1530, and 1700 hours in the kitchen. The June Temperature & Humidex Recording Tracking Sheet indicated that the temperature was recorded at 1000 and 1500 hours in the resident's rooms, main lounge, activity room, and laundry, and at 1000, 1200, 1500, and 1700 hours in the main dining room, and at 1000, 1200, 1530, and 1700 hours in the kitchen. No temperature was being measured and documented once every evening or night.

The gap in practice was brought to the DOC's attention who acknowledged that the home's practice was not in line with the legislation.

Sources: review of the home's Temperature & Humidex Record Tracking Sheet for May 15 through June 9, 2021, for all areas, interview with the DOC and other staff. [s. 21. (3)]

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 temperature is measured and documented in writing, at a minimum in the following areas of the home one resident common area on every floor of the home, which may include a lounge, dining area or corridor and shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #3: 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 the resident in accordance with the directions for use specified by the prescriber.

The home submitted a Critical Incident System (CIS) report related to a resident's missing controlled substance. Record review indicated that the controlled substance for the resident was signed and received by the home's staff but could not be located after a search of the home. The resident was ordered a scheduled dose of an identified controlled substance for pain twice daily. As a result of the missing controlled substance, the resident did not received two scheduled doses of the identified pain medication; instead they were administered half the strength of the scheduled pain medication therefore, the physician's order was not administered as ordered

The Registered Practical Nurses (RPNs) both confirmed that the resident was administered half the scheduled dose of pain medication on two identified dates instead of the complete dose ordered by the physician. This concern was brought to the DOC's attention. All staff acknowledged that the physician's order was not followed.

Sources: resident's health records, interview with RPNs, 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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 21st day of June, 2021

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

Original report signed by the inspector.