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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 31, 2022
Inspection Number 2022-1162-0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Tyndall Seniors Village Inc.

Long-Term Care Home and City
Tyndall Nursing Home, Mississauga

Lead Inspector
Slavica Vucko (#210)

Additional Inspector(s)
Goldie Acai (#751421)

Inspector Digital Signature
Slavica Vucko
Digitally signed by Slavica Vucko
DN: cn=Slavica Vucko, o, ou, email=slavica.vucko@ontario.ca, c=CA
Date: 2022.06.06 08:54:53 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 19, 24, 25, 26, 27, and 30, 2022

The following intake(s) were inspected:

- Intake # 001638-22 (Complaint) associated with intake 001729-22 (Critical Incident System Report (CIS) related to safe and secure home;
- Intake # 009031-22 (Complaint) associated with intake 008945-22 (CIS report) related to mandatory reporting of alleged abuse.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

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There were *findings of non-compliance*.

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

Findings of Non-Compliance were found during this inspection and were ***remedied*** prior to its conclusion. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

O. Reg. 79/10 s. 21. (2)

In December 2021 and January 2022 the home did not measure the ambient temperature in at least two resident bedrooms in different parts of the home, and the temperature was not 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 was not aware that they should measure the temperature in resident bedrooms in the wintertime.

This non-compliance was remedied when the home started measuring air temperatures in the resident bedrooms in February 2022, prior to this inspection.

Date Remedy Implemented: February 1, 2022 #210

WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s. 24. (1)*

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary
On a specified date a resident was transported in their wheelchair by staff to their unit. A staff member overheard the resident being restless and agitated.

The staff member who reported the incident was under the impression that the resident was approached by staff inappropriately because of the way the resident responded. The home was informed about this incident a month later and submitted a CIS report. Police was notified.

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Not reporting the alleged suspected abuse immediately, lead to a missed opportunity for immediate investigation of the incident**.**

Sources: interviews with staff, observation of the resident, review of home's investigation report and resident's clinical record.
#210

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.

- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.