Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: October 7, 2022	
Inspection Number: 2022-1162-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Tyndall Seniors Village Inc.	
Long Term Care Home and City: Tyndall Nursing Home, Mississauga	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature**
Additional Inspector(s) Maya Kuzmin (741674) Goldie Acai (741521)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 28, 29, 30, and October 4, 2022

The following intake(s) were inspected:

- Intake: #00001484-Complaint with concerns regarding sexual abuse to a resident by another resident.
- Intake: #00003241-Fall of a resident resulting in injury that required treatment.
- Intake: #00004593-Critical Incident related to unwitnessed fall from a resident resulting in injury.

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

Falls Prevention and Management
Infection Prevention and Control

Reporting and Complaints
Responsive Behaviours
Residents' Rights and Choices
Infection Prevention and Control

INSPECTION RESULTS

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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

The "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), directs homes to follow the Minister's Directive, in relation to hand hygiene. It directs the home to support residents to perform hand hygiene prior to receiving meals and snacks, and after toileting. The hand hygiene program includes access to hand hygiene agents, including 70-90 % alcohol.

Observation on September 28, and 30, 2022, on all floors, by inspectors #741521, #741674 and #210 indicated staff were using wipes for cleaning residents' hands before meals which did not contain at least 70% alcohol.

Observation on October 4, 2022, at lunch time on all floors indicated the residents were assisted with hand hygiene by staff using at least 70% alcohol-based hand rub.

Sources: review of "Infection Prevention and Control Standard for Long Term Care Homes April 2022" (IPAC Standard), observation, interview with staff and the IPAC practitioner.
[210]

Date Remedy Implemented: October 4, 2022.

NC #02 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

The "IPAC Standard for Long Term Care Homes April 2022" provides guidance for staff to follow IPAC routine practices and additional precautions. Specifically, proper use of PPE, including appropriate selection, application, removal, and disposal as required by Additional Requirement 9.1 (d) under the IPAC Standard.

The facility was in a COVID-19 outbreak, and staff were expected to wear procedural or surgical masks with a face shield as per Public Health recommendations for additional precautions, in addition to the facility's policy for droplet contact precautions. On a specified date, staff #117 was wearing a surgical mask without a face shield when entering a resident room and being within one meter of the resident. Staff #117 was directed to apply a face shield by staff #115 and performed accordingly.

Sources: "IPAC Standard for Long Term Care Homes April 2022," home's policy IC-D-20-APPENDIX A- Additional Precautions, dated February 26, 2021, interview with IPAC lead and observations.
[741521]

Date Remedy Implemented: September 28, 2022

WRITTEN NOTIFICATION: Responsive Behavior

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 58 (2) (b) (c)

The licensee has failed to ensure that for the responsive behaviour program, written strategies including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were (b) based on the assessed needs of residents with responsive behaviours; and (c) co-ordinated and implemented on an interdisciplinary basis.

The home's policy Behaviour Management Program, BML-05, indicates a program objective to identify and collaborate with external resources and/or psycho-geriatric professionals, when necessary, to provide appropriate care to residents with behavioural responses.

Two residents engaged in inappropriate sexual behaviour in common areas of the home on three separate occasions. Staff then started observing and preventing interactions of this nature. There was no assessment completed to determine capacity for consent to these sexual activities.

Both residents had different levels of cognitive performance.

The inspector interviewed both residents and determined that one of them had impaired memory. One resident wanted to maintain a friendship only with the other resident whereas the other one wanted sexual activities.

During separate interviews, the opinion of each resident about their relationship, including sexual aspects of the relationship, was conflicting.

There was no assessment completed (either observation or interview) in order to determine if the resident with declined cognitive impairment was capable of consenting to the sexual activities mentioned above. Also, there was no referral to specialized resources when the home was not able to assess the above.

Failure of the home to assess the resident's capacity for consenting to sexual activities, and implement coordinated interventions on an interdisciplinary basis to prevent, minimize or respond to the responsive behaviours led to the potential risk of unconsented sexual activities.

Sources: home's policy Responsive Behaviour Program BML-05, date November 1, 2021, observations, review of residents' clinical records, interview with residents and staff.
[210]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24

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 has occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director.

Subsection 2(1) (b) of O. Reg 226/22 defines sexual abuse as any non-consensual touching,

behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member**.**

1. Resident #003 presented with inappropriate sexual behaviour on a specified date. They touched another resident at their private area at a common area of the home.

The home was unable to demonstrate that an assessment was completed to evaluate if sexual activity was consented for by the cognitively impaired resident. The incident was not reported to the Director immediately.

Sources: review of resident's clinical records**,** interview with staff.
[210]

2. Progress notes detailed that resident #004 was found touching co-residents in common areas of the home on specified dates. These incidents were not reported to the director immediately.

Failure of the home to immediately report suspected sexual abuse of a resident by another resident to the Director led to a potential safety risk to residents in the home.

Sources: resident #004's clinical record, interview with staff.

[741521]

WRITTEN NOTIFICATION: Falls Prevention

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s 6 (7)

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

On two specified dates, resident #001 was observed sitting in a wheelchair with no falls device in place. Staff #100 confirmed this.

Resident #001's written plan of care for falls prevention, indicated an intervention that a device should be applied on the resident.

The lack of the provision of the fall prevention strategy as identified in resident #001's care plan increased the risk for further falls.

Sources: Critical Incident System (CIS) report, Falls Prevention and Management Program Policy dated May 20 2022, resident #001's clinical record, and interviews with staff.
[741674]