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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report (A1)

Report Issue Date: April 11, 2023	
Inspection Number: 2023-1162-0003	
Inspection Type: 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** Slavica Vucko Digitally signed by Slavica Vucko Date: 2023.04.11 09:08:15 -04'00'
Additional Inspector(s) Inspector Michael Chan (000708) was present during the inspection	

AMENDED INSPECTION REPORT SUMMARY

This Public report has been revised to reflect accurate numbering of noncompliance #001, #002 and #003. The inspection #2023-1162-0003 was completed on February 23, 2023.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13, 14, 21, 22, and 23, 2023.

The following intake(s) were inspected:

- Intake #00004164 - Critical Incident (CI) Injury of a resident of unknown cause resulting in hospital treatment;
- Intake #00005446 - CI Fall of a resident resulting in injury and hospital treatment;

The following intake(s) were completed in this inspected:

- Intake #00002588 - CI Fall of a resident resulting in hospital treatment;
- Intake #00005805 – CI Fall of a resident resulting in injury and hospital treatment.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

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. 115 (1)

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

The home was in Acute Respiratory Illness (ARI) outbreak on a specified date, with multiple residents and staff affected, and the Director was not immediately informed via the Critical Incident System (CIS) report or after hours call.

A CIS was submitted on February 13, 2023, and updated on February 15, 2023, that the outbreak was declared over by the Public Health (PH) unit.

Sources: interview with the home's IPAC lead, home observations and review of the CIS report.
Date Remedy Implemented: February 13, 2023.

[210]

WRITTEN NOTIFICATION: Cooling Requirements

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 23 (4) (b)

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was implemented by the licensee when the temperature in an area in the home measured by the licensee reached 26 degrees Celsius or above, for the remainder of the day and the following day.

Rationale and Summary

Observation and ambient temperature measurement on a specified date at different locations in the home indicated temperatures above 26 degrees Celsius.
As per the temperature log from February 2023 the same locations had temperatures higher than 26 degrees Celsius on multiple occasions.

As per the home's policy Air Temperature & Cooling requirements-Heat Related Illnesses Management, any temperature reading at or greater than 26 degrees Celsius must be reported to the Environmental Service Manager (ESM) and /or Senior Charge Nurse. Upon being alerted to a temperature reading at or greater than 26 degrees Celsius, the ESM or senior Charge Nurse will communicate to all departments of additional interventions and precautions to be implemented as outlined in the Contingency Plan.

After the inspector notified the home, interventions were implemented on particular days and the ambient temperatures mentioned above were lowered below 26 degrees Celsius, but they were not consistently kept under 26 degrees Celsius and ESM was not informed during all occasions. The home did not implement their heat related illness prevention and management plan when the temps were above 26 degrees Celsius

Failure of the home to monitor and adjust the air temperatures below 26 degrees Celsius for two consecutive days could place the residents at risk for heat related illnesses.

Sources: Observations, review of home's policy Air Temperature & Cooling requirements-Heat Related Illnesses Management, dated January 5, 2023, review of temperature logs for January and February 2023, interviews with staff.
[210]

WRITTEN NOTIFICATION: Plan of Care

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that resident #002's plan of care was reviewed and revised when care set out in the plan has not been effective.

Rationale and Summary

Resident #002 was transferred to hospital on a specified date, for an injury of unknown cause and was treated at the hospital. The injury led to a change in resident's health status and Activities of Daily (ADL) living.

Resident #002's care plan provided two options for transfer, one without device by one person and another one via a transfer device with two-people assist.
The Physiotherapist (PT) assessed resident #002's transfer method on a specified date, and indicated two-person assist and/or a transfer device when the resident was weak.

PSWs were transferring resident #002 via a transfer device for a period of approximately two months.

The quarterly Minimal Data Set (MDS) assessment from a specified date, did not reflect the transfer of resident #002 with assistance of a transfer device as documented in the Point of Care (POC) flow sheets.
Resident #002's written plan of care was not reviewed and revised when their care needs related to transfer changed.

Failure of resident #002's plan of care to be reviewed and revised when their activities of daily (ADL) living changed could lead to an inappropriate transfer and potential for injury.

Sources: review of resident #002's plan of care, home's policy Lifts & Transfers, dated March 19, 2020, observations and interview with staff.
[210]