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

Hamilton District
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Original Public Report

Report Issue Date: November 28, 2023	
Inspection Number: 2023-1162-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Tyndall Seniors Village Inc.	
Long Term Care Home and City: Tyndall Nursing Home, Mississauga	
Lead Inspector Carla Meyer (740860)	**Inspector Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.12.04 16:21:58 -05'00'
Additional Inspector(s) Emmy Hartmann (748)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23-27, 30-31, 2023 and November 1, 2023.

The following intake(s) were inspected:

- Intake: #00094378 - Proactive Compliance Inspection.

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Quality Improvement
Residents' and Family Councils
Resident Care and Support Services
Residents' Rights and Choices
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that a resident's plan of care was complied with.

Rationale and Summary
A resident's plan of care indicated that they were to receive honey thickened fluids due to swallowing problems.

During lunch meal observations on an identified date in October 2023, the resident was observed to have been served nectar thickened fluids, which was acknowledged by a Personal Support Worker (PSW) who was assisting the resident.

The Dietary Manager acknowledged that the resident was provided with the wrong textured fluids and that the plan of care for the resident was not followed by staff.

By not following the resident's plan of care, the resident was placed at risk for aspiration.

Sources: Observations; interview with a PSW and the Dietary Manager; and record review of resident clinical records. **[740860]**

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

A. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, and accessed by a resident.

Rationale and Summary
During the initial tour of the home on an identified date in October 2023, a resident was observed in bed with their call bell wrapped around a bed rail, and the call bell hanging almost touching the floor.

Two staff members verified that the resident's call bell was placed in a way that was not easily seen, and easily accessible by the resident.

The resident was high risk for falls due to unsafe ambulation; and staff were to ensure their call bell was within reach at all times, and reinforce the need to call for assistance.

The resident may have been at increased risk for falls when their call bell was not easily seen and accessible.

Sources: Observations; resident's care plan; interview with staff. **[748]**

B. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily accessed by a resident.

Rationale and Summary
A resident required one person extensive assistance for transferring, and continence care.

On an identified date in October 2023, they were observed using the washroom and a staff member identified that the resident had transferred themselves from their wheelchair to the toilet. This resident verified that they did not call for help and transferred on their own.

The call bell in the resident's room was observed laying on the floor between the resident's bed and a side table. The resident identified that they could not access the call bell easily.

The resident had a history of falls; one of which was related to reaching out for a call bell. Staff were to ensure that their call bell was within reach at all times, and to reinforce the need to call for assistance.

As a result of their call bell not being easily accessible, the resident had an increased risk of falling.

Sources: Observations; resident's care plan; and interview with the resident. **[748]**

WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

A. The licensee failed to ensure that the mechanical lift tub chairs and one tub in the home were kept in good repair.

Rationale and Summary
During Infection Prevention and Control (IPAC) observations, all mechanical lift tub chairs in the East side Tub and Shower room on the second, third, and fourth floor was noted to have an Out of Service

sign posted on them, and that the tubs were not visibly used by staff. The home also had a second Tub and Shower room on the West side of the building, however the tubs in these rooms were no longer being utilized as it was not suitable for resident use due to its type. There were no resident home areas on the first floor.

The home's Facility Service Manager (FSM) clarified that only one tub out of the three was not working due to an electronic board issue but acknowledged that all three mechanical lift tub chairs necessary to be used with the tubs were out of service due to issues with their chargers. The FSM also acknowledged that this resident equipment has not been used for approximately one year.

The Executive Director (ED) informed the inspector that they were aware that one tub was not functioning, but that they were not aware that all mechanical lift tub chairs were out of service. They stated that the home is looking to replace them but that they have not received approval from corporate. They also acknowledged that there is a concern with meeting resident preferences if a resident did prefer or requested to have a tub bath due to these issues.

By failing to ensure that resident equipment provided by the home were kept in good repair, there was a low risk to resident choices being impacted.

Sources: Observations; interview with Housekeeping staff, the FSM, and the ED; and review of the home's Maintenance Program and policies. **[740860]**

B. The licensee failed to ensure that resident equipment provided by the home was kept in good repair.

Rationale and Summary
During IPAC observations, a sit-to-stand mechanical lift was observed on the second floor, East side Tub and Shower room that had part of the rubber covering broken on the right handlebar used by residents to grab onto. This handle was covered with duct-tape.

Another sit-to-stand mechanical lift was observed on the third floor, East side Tub and Shower room which also had the tip of the rubber covering on the right handlebar broken, and the metal edges exposed.

The FSM acknowledged that these mechanical lifts should have been tagged and removed from the floor to be fixed due to safety concerns, and that duct-tape should not have been used to cover the handles.

The home's policy titled, Mechanical Lifts, last revised February 21, 2023, also stated that all mechanical lifting devices used to assist in the transfer/movement of persons served will be maintained in good working condition to prevent injury to persons served and to staff.

By not keeping resident equipment such as the sit-to-stand mechanical lifts in good repair, there is an increased risk of the transmission of infection and injury to residents.

Sources: Observations; observations with MOL inspector; interview with the FSM; and review of the home's Maintenance Program and policies. **[740860]**

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6. i.

The licensee failed to ensure that the home's Continuous Quality Improvement (CQI) initiative report contained the required information.

Rationale and Summary
As per O.Reg. 246/22, s.168 (2) 6. i., the home's CQI initiative report must contain a written record of the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions.

A review of the home's CQI initiative report posted on the home's website showed that the following information stated above was not included in the report.

The licensee failed to ensure that they have met the requirements under the Act and the regulations.

Sources: Review of the home's website and CQI initiative report; and interview with the CQI Lead and RAI-MDS Coordinator. **[740860]**