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: December 20, 2023	
Inspection Number: 2023-1162-0005	
Inspection Type: Critical Incident	
Licensee: Tyndall Seniors Village Inc.	
Long Term Care Home and City: Tyndall Nursing Home, Mississauga	
Lead Inspector Amanpreet Kaur Malhi (741128)	**Inspector Digital Signature** Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2023.12.21 12:39:55 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-8, 12-15, and 19, 2023

The following intake(s) were inspected:

- Intake #00085425, CI #2656-000009-23 related to fall of a resident resulting in a significant change in health status.
- Intake #00093737, CI #2656-000020-23 related to Emergency/ Fire in the elevator electrical room.
- Intake #00097619, CI #2656-000022-23 related to resident's choking incident

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to update or revise resident #001's plan of care when their care needs changed after their fall.

Rationale and Summary

Resident #001 had a fall. The Post-fall huddle form completed after their fall, identified the need to remind resident #001 to use their call bell as the

recommended fall intervention or strategies, but this intervention was not added to their plan of care until eight months later.

RPN #108 stated resident #001 required frequent reminders to call for assistance and had more falls in the last quarter related to them not calling for help.

Sources: Resident #001's clinical records, Fall's policy, INDEX: FP-P-20, last revised: May 1, 2023, Interview with PSW #107, RPN #108, and Fall leads #104 and #105.

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WRITTEN NOTIFICATION: Emergency plans

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (5) 4.
Emergency plans
s. 268 (5) The licensee shall ensure that the emergency plans address the following components:
4. Specific staff roles and responsibilities.

The licensee failed to ensure the staff complied with their specific fire safety plan roles and responsibilities when Code Red was announced at the home on August 2, 2023.

Rationale and Summary

The home's fire safety plan, last revised July 13, 2022, required the person discovering the fire or smoke to call out loudly "Code Red". At the sound of the

alarm, the second floor nurse or designate was to go to the annunciator panel near by and read the zone and location shown on the display. Announce "Code Red" location, loudly and clearly over the P.A system, three times. This was to be done by who could do it first. (Do not wait for someone else). The third floor charge nurse would go to the ground floor to fire panel to provide direction via the voice communication system.

A) The fire alarm went off at the home. Smoke was noted coming out of the laundry room vent. However, the fire panel indicated the source of the problem was in the elevator room.

The Emergency Occurrence Summary, Evaluation and Analysis completed post incident by Administrator #100, indicated that staff who first discovered the smoke announced the Code Red in the laundry room without checking the fire panel first for specific location, and this led to some confusion.

Environmental Services Manager #116 stated that the first overhead announcement indicated that the fire was in the laundry, but when they checked the fire panel, they identified the problem was with the elevators.

Administrator #100 stated that staff should have checked the fire panel before making the announcement.

B) The third floor charge nurse when they heard another staff member make the Code Red announcement, stayed put on the third floor with residents and did not go downstairs to the main floor.

The Emergency Occurrence Summary, Evaluation and Analysis mentioned that staff on the main floor waited for directions instead of assisting in the dining room or

evacuating.

Administrator #100 stated that when the fire department arrived they directed the main floor staff to evacuate.

When staff failed to comply with their fire safely plan roles and responsibilities, it led to confusion and delayed response.

Sources: CI #2656-000020-23, Home's Fire Safety Plan, last revised July 13, 2022, and Interviews with Environmental Services Manager #115, RN #105, and Administrator #100.

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