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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Public Report

Report Issue Date: June 11, 2025
Inspection Number: 2025-1828-0001
Inspection Type: Critical Incident
Licensee: Tyndall Seniors Village Inc.
Long Term Care Home and City: Tyndall Nursing Home - Erin Mills Site, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4, 5, 9, 10, 11, 2025

The following intake(s) were inspected:

- Intake: #00147089 - Critical Incident (CI) #2656-000002-25 - Related to falls prevention and management.

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

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care outlined in Resident's plan of care, specifically related to fall prevention interventions, was provided as specified.

During an observation, the resident's call bell was not within reach, contrary to the requirements of the care plan. In an interview, the resident confirmed they were unable to reach the call bell.

Subsequently, staff entered the room and repositioned the call bell to be within the resident's reach.

Sources: Resident clinical records, observation of the resident's room, and staff interviews.

Date Remedy Implemented: June 5, 2025