Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 6, 2014	2013_239503_0006	T375, T378, T366, T624-13	Complaint

Licensee/Titulaire de permis

341822 ONTARIO INC
28 HALTON STREET, TORONTO, ON, M6J-1R3

Long-Term Care Home/Foyer de soins de longue durée

MAYNARD NURSING HOME
28 HALTON STREET, TORONTO, ON, M6J-1R3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LAURA BROWN-HUESKEN (503), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 17, 18, 23, 24, 30, 2013

This inspection included logs # T-590-13 and T-658-13

During the course of the inspection, the inspector(s) spoke with Residents, family members, Personal Support Workers, Registered Nursing Staff, Food Services Supervisor, and Director of Care.

During the course of the inspection, the inspector(s) observed lunch meal service, toured second floor resident rooms, observed provision of resident care, reviewed pest control records, reviewed food temperature audits, reviewed clinical records, reviewed policies related to meal service, therapeutic diets, nutritional supplements and palliative care, and reviewed staffing plan and schedules.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Food Quality
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

Interview with Registered Practical Nurse (RPN) and review of Registered Dietitian (RD) assessment notes from an identified date indicate resident 001 consumed regular texture food without difficulty and generally consumed full meals prior to hospitalization on an identified date. Following readmission from hospital nursing progress notes for resident 001 indicate that the resident was experiencing difficulty swallowing. Nursing progress notes further indicate that resident 001 consumed only fluids for an identified time period after readmission. Interview with RPN confirmed poor intake and further indicated that an unplanned intervention of nutritional supplements was being provided to the resident due to the poor intake of meals. Resident 001's written care plan instructed staff to provide resident with regular diet, regular texture despite the noted change in swallowing ability and intake, and was not revised to reflect the resident's change in care needs. [s. 6. (10) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutritional Supplements policy was complied with.

The home's Food Service, Nutritional Supplements policy, document number RCM-K-75-50 revised August 2013, states that nutritional supplements are to be provided to residents as specified by Physician's order. On an identified date an identified RPN was observed providing resident 001 with a nutritional supplement. The RPN identified the nutritional supplement as Boost. In an interview with the RPN it was confirmed that there was no Physician's order for the supplement. An interview with the Director of Care (DOC) confirmed that nutritional supplements should not be provided to residents without a Physician's order. [s. 8. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that a registered dietitian who is a member of the staff of the home completes a nutritional assessment whenever there is a significant change in a resident's health condition.

Resident 001's written plan of care instructs staff to provide resident regular diet, regular texture for meals. Interview with RPN and review of RD assessment notes indicate resident ate regular texture food without difficulty and generally ate full meals prior to hospitalization on an identified date. Interview with RPN and review of nursing progress notes indicate that upon readmission on an identified date, the resident had a change in condition and was experiencing swallowing difficulties. Further, the resident consumed only fluids for an identified time period following readmission from hospital. An interview with the DOC confirmed that when a resident experiences a significant change such as a difficulty chewing or swallowing it is the home's procedure that the RD would complete an assessment, and implement interventions as needed. The home's RD did not complete an assessment in three weeks following the readmission from hospital. [s. 26. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of three meals daily.

On an identified date the inspector observed resident 001 in the resident's room during the lunch meal. The resident was provided only fluids. In an interview, resident 001 confirmed that the lunch was not offered. An identified RPN indicated that due to the resident's health status and complaints of pain, resident was only provided fluids. Resident 001's written plan of care instructs staff to provide a regular diet, regular texture. An interview with the DOC confirmed that resident 001 should have been offered food, in addition to fluids, at all meals. [s. 71. (3) (a)]

Issued on this 7th day of January, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

L Brown-Hueston