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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 6, 2016	2016_449619_0013	004065-14	Complaint

Licensee/Titulaire de permis

TYNDALL NURSING HOME LIMITED
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

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

TYNDALL NURSING HOME
1060 EGLINTON AVENUE EAST MISSISSAUGA ON L4W 1K3

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

SAMANTHA DIPIERO (619)

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): March 30 & 31, 2016 and June 27, 2016

The purpose of this inspection to was to inspect complaint log #004065-14 related to nutrition and hydration

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Behavioural Support Ontario (BSO) nurse, registered nurse, registered dietician, personal support worker, and the complainant. The inspector also toured the facility, and observed the provision of care during meal time.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #002 was identified as a high nutritional risk and also identified as having chewing difficulties and was designated a special diet by the registered dietician on admission to the home. PSW #105 was aware that the resident required a special texture diet, stating that the kitchen was responsible for preparing the food items. A review of the homes policy titled "Nutrition Care", policy #DTY-A-10, effective date February 2012, stated that staff were responsible for "ensuring the meals, snacks, and beverages are provided to support resident's optimal nutrition status, and to manage nutrition and hydration issues according to the resident's needs and preferences". Interview with registered staff #103 confirmed that the resident required a special texture diet and indicated that regular texture foods were potentially harmful to the resident. Interview with Administrator confirmed that the resident was at an increased risk of poor intake and choking and that the resident's diet, as outlined in the plan of care, was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with s. 6. (7) where the licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.
Resident #002 was identified as a high nutritional risk by the homes registered dietician after an assessment was completed in January 2010. With the consent of the resident's family, planned a personalized menu for the resident that adequately addressed the resident's and family's dietary preferences. A review of the resident's care plan, last updated in March 2015, indicated that the resident's breakfast meal preferences included specific foods items however, on several specified dates between June, July and August 2014, several menu items were noted to be missing from the resident's breakfast meal tray. Interview with PSW # 105 indicated that the resident would have been unable to communicate to the staff if a menu item was missing from their tray and that in the past staff had been alerted to missing food items by visiting family members. Interview with registered staff #103 confirmed that the resident regularly took their breakfast meal over other meals during the day. A review of the homes policy titled "Nutrition Care", policy #DTY-A-10, effective date February 2012, stated that staff are responsible for "ensuring there are menu items available to provide for each resident's individualized nutrition and hydration needs". Interview with Administrator confirmed that staff were responsible for checking the meal tray to ensure that all ordered food items were present and available to the resident and confirmed that the planned menu items for resident #001 were not available at each meal. [s. 71. (4)]

Issued on this 7th day of July, 2016

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

Original report signed by the inspector.