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

Division de la responsabilisation et de la performance du système de santé
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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
Jul 2, 2014	2014_300560_0011	H-000826-13/H-000685-13	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

SUSAN PORTEOUS (560), LESLEY EDWARDS (506)

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): June 11, 12 and 13, 2014

This inspection includes log # H-000318-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), personal support workers (PSW's), Resident Assessment Instrument (RAI) Coordinator, registered staff and residents.

During the course of the inspection, the inspector(s) reviewed clinical records, the home's relevant policies and procedures and internal investigative notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Safe and Secure Home

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that the written plan of care for resident #001 set out clear directions to staff and others who provided direct care.

The written plan of care for resident #001 indicated that the resident was to be toileted as per their schedule, however there was no toileting schedule in place for the resident. A staff member confirmed they were unaware of what times to take the resident to the washroom as there were no toileting times listed in the plan of care. The Resident Assessment Instrument (RAI) co-ordinator confirmed that the resident should have had a list of times in the plan of care to indicate when the resident needed to be toileted.

The ADOC confirmed that the direct care staff were not provided with clear direction for toileting resident #001 as there was no toileting schedule in place. [s. 6. (1) (c)]

2. The written plan of care instructions for resident #002 did not set out clear directions to staff and others who provided direct care.

The care plan for resident #002 was not revised until May 2013 to indicate the resident was on bed rest since readmission to the home in April 2013 with an injury. Identified care plan instructions in place prior to the resident sustaining the injury had not been removed when it was revised. The toileting section directed the resident sit

on the toilet and receive bed changes for toileting due to bed rest. The bathing section directed the resident to receive tub baths and while on bed rest be provided with a bed bath.

The DOC confirmed in an interview in June 2014 that the plan of care was not accurately revised when the resident's care needs changed. [s. 6. (1) (c)]

3. The licensee did not ensure that resident #001 was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective.

Resident #001’s plan of care indicated that the resident was at high risk for falls. Resident #001 experienced several falls from March 2012 until May 2012 indicating that the interventions in the plan of care were not effective. The plan of care interventions were not revised until June 2012. This information was confirmed by the resident’s health record and the ADOC. [s. 6. (10) (b)]

4. The licensee did not ensure that resident #002 was reassessed and the resident's plan of care reviewed and revised when their care needs changed.

In April 2013 the resident was transferred to the hospital and diagnosed with an injury. Progress notes indicate that in April 2013 the resident had been readmitted to the home on bed rest. The document the home refers to as the care plan was not revised until May 2013 to identify the resident was on bed rest and required bed changes for toileting.

The DOC confirmed during an interview in June 2014 the care plan should have been revised when the resident was readmitted to the home and their care needs had changed. [s. 6. (10) (b)]

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 to ensure the written plan of care sets out clear directions to staff and others who provide direct care to residents and that residents are reassessed and their plan of care reviewed and revised when their care needs change and when care set out in their plan is not effective, to be implemented voluntarily.

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 did not ensure that their pain management policy was complied with in relation to resident # 002.

The home's pain management policy was reviewed. The policy directs staff to initiate a pain flow record to assess and monitor residents with identified pain until it is stabilized and under control. The home also utilizes a weekly pain flow record to assess and monitor residents on scheduled pain medication.

Resident #002 was identified to be at risk for pain due to multiple medical diagnoses. The resident's plan of care indicated they were to be assessed weekly, quarterly and as needed (PRN) for pain. On an identified day in April 2013 the resident received scheduled Tylenol four times during the day and Tylenol PRN twice in the evening for complaints of pain.

A review of the resident's clinical record for the identified day in April 2013 revealed no documentation of a pain assessment being completed after 0920 hours.

In June 2014 during an interview the DOC confirmed that a pain flow record should have been initiated according to the home's policy when the resident complained of pain. The DOC confirmed that the policy was in effect during the month of April 2013. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 4th day of July, 2014

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