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
Direction de l'amélioration de la performance et de la conformité

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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
Aug 21, 2013	2013_190159_0021	H-000241-13H-000318-13	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

ASHA SEHGAL (159)

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): July 31, August 1, 2013

During the course of the inspection, the inspector(s) spoke with the administrator, the Director of Care, registered staff, Food Service Manager, Personal Support Workers(PSWs),dietary staff, residents and family members.

During the course of the inspection, the inspector(s) observed meal service, reviewed health records and policies and procedures specific to nutrition and hydration, continence care and bowel management.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Nutrition and Hydration

Personal Support Services

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. (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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. [LTCHA, 2007, S.O. 2007, c.8,s.6(1)(c)]
The plan of care for resident #0002 did not set clear direction for staff and others who provided direct care to the resident.
A)The plan did not provide clear direction to staff related to provision of diet. The "Nutrition risk" focus of the resident's plan of care directed the staff to provide minced food texture and regular fluids, however, under the interventions section the plan stated to provide pureed texture, honey consistency thickened fluids. The different sections of the plan of care were not consistent in relation to fluid and food consistency required for the resident. [s. 6. (1) (c)]

2. B)The plan of care for resident #0003 did not provide clear direction for staff and others who provided direct care to the resident.
The "Nutrition " focus of the resident's plan of care directed resident fluid restriction of 1500-1560ml per day, however, under the interventions section directed resident fluid restriction of 1200-1225 ml per day. The different sections of the plan of care were not consistent in relation to fluid restriction required for the resident.
Resident #0003 had a doctor's order for a therapeutic diet, regular texture, staff to cut up meat in bite size pieces, fluid restriction. The "Eating " focused section of the resident's plan of care directed staff to provide therapeutic diet, pureed texture, fluid restriction. The interventions under the "Nutrition" focus directed the staff to provide Regular texture. Inconsistencies were noted in different sections of the plan of care and the diet order in relation to texture of the diet. [s. 6. (1) (c)]

3. C)The plan of care for resident #0001 did not provide clear direction for staff in relation sodium restricted diet. Interview with the staff confirmed that the planned menu and the diet notes did not include specific directions for sodium restricted diet. The resident was served an inappropriate menu item at dinner i.e. smoked beef brisket instead of roast beef. . [s. 6. (1) (c)]

4. [LTCHA, 2007, S.O. 2007 c.8,s.6(7)]
The care set out in the plan of care was not provided to residents as specified in the plan.
A) Resident # 0003 had a doctor's order for fluid restriction. The plan directed the staff to provide 125 ml soup, 125ml milk OR 125ml juice OR 125ml water and 125 ml tea/coffee at lunch. During the noon meal service the resident was observed in the dining and was served 200ml Milk, 125ml soup, 200ml tea (in a mug), and 125 ml water. The identified resident did not receive the amount of fluids specified in the diet

notes and the plan of care. The plan of care dated April 2013 stated " need to monitor fluids and electrolytes related medical diagnosis. The Nutrition Risk and Hydration clinical assessment completed by the registered dietitian May 2013 identified resident at high nutritional risk related to fluid restriction. [s. 6. (7)]

5. B) The plan for Resident #0001 indicated the resident had a physician's order for a therapuetic diet, regular texture, fluid and sodium restriction. The diet notes and the plan of care stated resident to be provided at lunch meal 125ml milk, 125ml soup or diet juice or water and 180 ml tea and at dinner 125ml milk, 125ml water or diet juice and 180ml tea/coffee. July 2013 during the lunch meal, the resident was served 200ml milk, 125ml soup, and 200ml tea and was served at dinner 125ml milk, 125ml water, 125ml regular apple juice and 200ml tea. Observation of the resident and interview with the staff indicated the resident did not receive the amount of fluids as per the plan of care.
The resident had a doctor's order for sodium restricted diet. July 2013 during the supper meal the resident received regular dinner menu consisted of salty entrée i.e. smoked beef brisket, potatoes Au Gratin, buttered cabbage. The plan stated to provide modified diabetic diet, sugar was provided instead of sweetener.
The plan of care stated to provide nutritional Supplement one scoop at breakfast in cereal and one scoop at lunch in soup, however, the intervention was not provided at the lunch meal. Interview with the dietary staff confirmed staff was not aware of the contents of the resident's plan of care.
The plan of care directed staff to monitor resident's fluid intake and output every shift. However, there was no indication that the intake and output was monitored every shift and documented. The Director of Care and the Registered Practical Nurse confirmed that the staff did not monitor and document fluid intake and output every shift. The plan of care had identified that resident was at risk and needed monitoring for medical dignosis.
The Minimum Data Set quarterly assessment completed on May 2013 indicated resident was at high nutritional risk.[s. 6.(7)]

6. [LTCHA, 2007, S.O. 2007 c.8,s.6(8)]
The licensee did not ensure that staff and others who provide direct care to the resident were aware of the contents of the resident's plan of care and had convenient and immediate access to it.
A)The staff did not have access to resident #0003's nutrition and hydration plan of care. The resident had a doctor's order for fluid restriction. The electronic plan of care

for the identified nutritional needs was created in December 2011 and revised in July 2013. The hard copy had a print date of June 2013 and did not include the focus statement regarding nutrition and hydration needs. The hard copy is the plan which direct front line staff, who do not have computer access. Not all direct care staff have immediate access to the computerized plan. Interview with the Director of Care and the Administrator confirmed that the hard copy of the care plan did not include the plan and the interventions related to nutrition and hydration assessed needs and the front line Personal Support Workers (PSWs) did not have access to the electronic plan. [s. 6. (8)]

7. B)The staff and others who provide direct care to the resident did not have access to Nutrition and Hydration plan of care for resident # 0001. The hard copy is the plan which would direct front line staff, who do not have computer access. This version of the plan had a print date of March 2013 did not include the focus statement regarding Nutrition and Hydration needs and nutritional interventions related to specified diagnosis. Interview with the Director of Care and the Administrator confirmed that not all direct care staff have convenient or immediate access to the electronic plan. [s. 6. (8)]1

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 3rd day of September, 2013

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ASHA SEHGAL (159)
Inspection No. / No de l'inspection :	2013_190159_0021
Log No. / Registre no:	H-000241-13H-000318-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 21, 2013
Licensee / Titulaire de permis :	TYNDALL NURSING HOME LIMITED 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
LTC Home / Foyer de SLD :	TYNDALL NURSING HOME 1060 EGLINTON AVENUE EAST, MISSISSAUGA, ON, L4W-1K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patricia Bedord

To TYNDALL NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will ensure that clear direction is provided to staff and others providing direct care to residents in relation to diets and monitoring fluid restriction.

The plan is to be submitted by September 15, 2013 to Long Term Care Homes Inspector, Asha Sehgal at Asha.Sehgal@ontario.ca.

Grounds / Motifs :

1. The plan of care for resident #0001 did not provide clear direction for staff in relation to low sodium diet. Interview with the staff confirmed that the planned menu and the diet notes did not include specific directions for low sodium diet. July 2013, resident was served an inappropriate food item at dinner i.e. smoked beef brisket instead of roast beef. (159)

2. The plan of care for resident #0003 did not provide clear direction for staff and others who provided direct care to the resident.
The "Nutrition " focus of the resident's plan of care directed resident fluid restriction of 1500-1560ml per day, however, under the interventions section directed resident fluid restriction of 1200-1225 ml per day. The different sections of the plan of care were not consistent in relation to fluid restriction required for the resident.
Resident #0003 had a doctor's order for a therapeutic regular texture diet, staff to cut up meat in bite size pieces and fluid restriction. The "Eating " focused section of the resident's plan of care directed staff to provide therapeutic pureed texture and fluid restriction. The interventions under the "Nutrition" focus directed the staff to provide Regular texture. Inconsistencies were noted in different sections of the plan of care and the diet order in relation to texture of the diet. (159)

3. The plan of care for resident #0002 did not set clear direction for staff and others who provided direct care to the resident.
The plan did not provide clear direction to staff related to provision of diet. The "Nutrition risk" focus of the resident's plan of care directed the staff to provide minced food texture and regular fluids, however, under the interventions section the plan stated to provide pureed texture, honey consistency thickened fluids. The different sections of the plan of care were not consistent in relation to fluid and food consistency required for the resident. (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures the care set out in the plan of care is provided to residents, including resident #0001, #0002, #0003, as specified in the plan, related to provision of diet and hydration needs.

The plan is to be submitted by September 15, 2013 to Long Term Care Homes inspector Asha Sehgal at: Asha .Sehgal@ontario.ca

Grounds / Motifs :

1. Previously issued as an order in June 2013
The care set out in the plan of care was not provided to residents as specified in the plan.
a) The plan for Resident #0001 indicated the resident had a physician's order for a therapeutic regular texture diet and sodium and fluid restriction.. The diet notes and the plan of care stated resident to be provided at lunch meal 125ml milk, 125ml soup or diet juice or water and 180 ml tea and at dinner 125ml milk, 125ml water or diet juice and 180ml tea/coffee. July 2013 during the lunch meal, the resident was served 200ml milk, 125ml soup, and 200ml tea and at dinner served 125ml milk, 125ml water, 125ml regular apple juice and 200ml tea. Observation of the resident and interview with the staff indicated the resident did not receive the amount of fluids as per the plan of care.
b) The resident had a doctor's order for low sodium diet. July 2013 during the supper meal the resident received regular dinner menu consisted of salty entrée i.e. smoked beef brisket, potatoes Au Gratin, buttered cabbage.
c) The plan stated to provide modified diabetic diet, sugar was provided instead of sweetener.

d) The plan of care stated to provide nutritional Supplement one scoop at breakfast in cereal and one scoop at lunch in soup, however, the intervention was not provided at the lunch meal July 2013. Interview with the dietary staff confirmed staff was not aware of the contents of the resident's plan of care.
e) The plan of care directed staff to monitor resident's fluid intake and output every shift. However, there was no indication that the intake and output was monitored every shift and documented. The Director of Care and the Registered Practical Nurse confirmed that the staff did not monitor and documente fluid intake and output every shift. The plan of care had identified the resident was at risk and needed monitoring related to specified diagnosis. The Minimum data set quarterly assessment completed May 2013 indicated resident was at high nutritional risk due to specified diagnosis..
(159)

2. Resident # 0003 had a doctor's order for fluid restriction. The plan directed the staff to provide 125 ml soup, 125ml milk OR 125ml juice OR 125ml water and 125 ml tea/coffee at lunch. July 2013 during the noon meal service the resident was observed in the dining and was served 200ml Milk, 125ml soup, 200ml tea (in a mug), and 125 ml water. The identified resident did not receive the amount of fluids specified in the diet notes and the plan of care. The plan of care dated April 2013 stated " need to monitor fluids and electrolytes related to specified diagnosis. The Nutrition Risk and Hydration clinical assessment completed by the registered dietitian May 2013 identified resident at high nutritional risk related to specified diagnosis.
(159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of August, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : ASHA SEHGAL

Service Area Office / Bureau régional de services : Hamilton Service Area Office