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 sions 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
Apr 20, 2016	2016_355588_0008	004710-16	Complaint

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF WATERLOO
150 Frederick Street KITCHENER ON N2A 4J3

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

SUNNYSIDE HOME
247 FRANKLIN STREET NORTH KITCHENER ON N2A 1Y5

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

CHRISTINE MCCARTHY (588)

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 1, 2, 3, 4, 7, 8, 9, 10, 14, 2016.

This complaint was completed concurrently alongside of RQI 002280-15, as a Complaint IL-42858-LO, MOH Log #004710-16, related to Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the complainant, four Personal Support Workers, one Personal Support Worker-Behaviour Support Ontario, one Resident Care Coordinator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken to meet the needs of the resident with responsive behaviours include:
assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Record review of Progress Notes in Point Click Care for a specified time-frame, revealed numerous references to Resident #036 having exhibited behaviours.

Record Review of Care Plan for a specified time-frame, identified strategies to address the behaviours.

Record review of Assessments in Point Click Care, revealed an absence of a Responsive Behaviours Assessment.

Record review of Progress Notes in Point Click Care revealed that the home referred Resident #036 to Behaviour Supports Ontario (BSO) for assessment, only after an escalation in behaviours and subsequent change in physical status.

Record Review of the hard copy "Behaviour Supports Ontario" Binder revealed an absence of documentation for Resident #036, prior to the escalation in behaviours and subsequent change in physical status.

Interview with staff #102, Resident Care Coordinator on March 14, 2016 revealed that responsive behaviours were addressed on the units by the staff, after referral, consultation and assessment by the Behaviour Supports Ontario-Personal Support Worker (BSO-PSW) and Behaviour Supports Ontario Registered Nurse (BSO-RN). Staff #102, Resident Care Coordinator confirmed that the expectation of the home was that there should have been a Responsive Behaviours Assessment completed for Resident #036 prior to the escalation in behaviours and subsequent change in physical status, and this was not done. [s. 53. (4) (c)]

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 that actions taken to meet the needs of residents' exhibiting responsive behaviours, include assessment, reassessment, interventions, and documentation of the resident's responses, to be implemented voluntarily.

Issued on this 20th day of April, 2016

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

Original report signed by the inspector.