



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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
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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
Aug 13, 2015	2015_254610_0032	017489-15	Critical Incident System

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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 12, 2015,

This critical incident inspection was related to abuse and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator of Resident Care, Resident Care Manager, Staff Educator, one Registered Nurse, one Personal Support Worker, Resident Care Coordinator/Behavioural Support Team Lead and one Resident.

The inspector reviewed health care records, relevant policies and internal investigation documentation, conducted interviews and observed resident care.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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



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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 were taken to meet the needs of the resident with responsive behaviours which would include assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

On August 11, 2015, a review of the Behavioural Support Team binder showed that a resident had a plan completed by the Behavioural Support Team (BSO) for trial interventions and the care plan review for behavioural problems with the focus, goals, and interventions was last reviewed in 2014.

Review of the BSO Team binder did not show any further reassessment or interventions since the trial interventions were implemented.

The Resident Care Manager confirmed On August 11, 2015, that the BSO Team binder would have the most current up to date approaches to care, with the interventions on approaches, techniques and suggestions from the BSO team.

The Behavioural Support Team Lead/Resident Care Coordinator confirmed that there should have been a reassessment of the trial intervention for the resident with the most current focus and goals with written strategies, including techniques and interventions to prevent and respond to resident responsive behaviours.

The licensee has failed to ensure that actions had been taken to meet the needs of the resident's responsive behaviours which would include assessment, reassessments, interventions, and documentation of the resident's responses to the interventions. [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 for each resident demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessment, reassessments, interventions, and that the resident's responses to interventions are documented, to be implemented voluntarily.



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Issued on this 14th day of August, 2015

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

Original report signed by the inspector.