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
Mar 15, 2016	2016_263524_0007	002280-16	Resident Quality Inspection

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

INA REYNOLDS (524), CHRISTINE MCCARTHY (588), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 1, 2, 3, 4, 7, 8, 9, 10, 11, 2016.

The following Critical Incident and Follow-up inspections were conducted concurrently during this inspection:
Log # 027280-15 / CI M578-000032-15 related to a fall
Log # 028869-15 / CI M578-000036-15 related to allegations of abuse
Log # 030673-15 / CI M578-000038-15 related to a fall
Log # 031157-15 / CI M578-000039-15 related to allegations of abuse
Log # 000254-16 / CI M578-000001-16 related to a fall
Log # 001470-16 / CI M578-000003-16 related to allegations of abuse
Log # 002159-16 / CI M578-000006-16 related to allegations of abuse
Log # 005685-16 / CI M578-000008-16 related to allegations of abuse
Log # 006171-16 / CI M578-000014-16 related to allegations of abuse
Log # 033931 related to follow-up to CO #001

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Resident Care Coordinators, one Food Services Supervisor, the Housekeeping & Laundry Supervisor, the Restorative Care Supervisor, the Infection Control Supervisor, three Registered Nurses, eight Registered Practical Nurses, eight Personal Support Workers, one Unit Clerk, one Resident Housekeeping Assistant, 46 Residents and three Family Members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal and snack service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, investigation notes and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_303563_0046	588

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Record review of the home's Critical Incident Reporting Investigation on March 8, 2016, revealed an incident of resident to resident abuse on a specified date. The Resident Care Coordinator (RCC) initiated an investigation immediately upon hearing of the incident and appropriate actions were taken in response to the incident. Review of the Long-Term Care Homes Critical Incident System used to report incidents to the Director, failed to identify a report related to the identified incident.

Review of the home's policy "Resident Abuse & Neglect Zero Tolerance" Policy #7-10 dated May 12, 2015, states all persons who witness or suspect abuse and/or neglect must report it in accordance with the reporting procedures in this policy.

The RCC confirmed that the incident had not been reported immediately to the Director. Interview with the Administrator confirmed that it was the home's expectation that the abuse of a resident must be reported to the Director in accordance with the home's policy. [s. 20. (1)]

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 the policy to promote zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the organized program of nutrition care and dietary services was implemented.

The following policy was not implemented:
The home's "Weight" policy # w-40 dated February 14, 2014 directed staff to "weigh each resident on the first day of each month or more" if requested by the physician or Registered Dietitian. Record review on March 3, 2016, revealed no documentation of monthly weights recorded for an identified resident for a lengthy period of time.

Staff interview on March 4, 2016, with the Director of Care (DOC) confirmed that a resident's weights were not taken and recorded for a lengthy period of time. Staff interview on March 5, 2016, with the Administrator confirmed that it is the expectation of the home that residents were weighed on a monthly basis. [s. 68. (2) (a)]

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 organized program of nutrition care and dietary services is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was immediately notified of an alleged, suspected or witnessed incident of abuse or neglect of a resident that caused distress to the resident that could have potentially been detrimental to the resident's health or well-being.

A) A critical incident occurred on a specified date, as reported by the home, involving an identified resident and a staff member. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved. Record review revealed the notification of the SDM occurred four days after the incident happened.

Staff interview on March 10, 2016, with the Resident Care Coordinator (RCC) revealed that the Substitute Decision-Maker (SDM) for the resident was not notified immediately of

an alleged incident.

Staff interview on March 10, 2016, at 1045 hours with the Director of Care (DOC) confirmed that was the home's expectation that the resident's Substitution Decision-Maker be notified immediately when the home becomes aware of an alleged abuse of a resident.

B) A critical incident occurred on two specified dates, as reported by the home, involving an identified resident and a staff member. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved. Record review revealed the notification of the SDM occurred six days after the incident happened.

The Resident Care Coordinator on March 8, 2016, confirmed that it was the home's expectation that incidents that could be detrimental to the health and well-being of the resident were to be immediately reported to the SDM and in the case of the incident between the resident and a staff member there was no documented evidence that this occurred and should have.

C) A critical incident occurred on a specified date, as reported by the home involving an identified resident and a staff member. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved. Record review revealed there was no documented evidence that the SDM was immediately notified of the witnessed incident. This was confirmed by the Resident Care Coordinator on March 10, 2016.

Review of the home's "Resident Abuse & Neglect Zero Tolerance" policy #7-10 dated May 12, 2015, directed staff to "immediately notify a resident's substitute decision maker" upon becoming aware of an alleged, suspected or witnessed incident of abuse that could potentially be detrimental to the resident's health or well-being.

Interview with the Director of Care on March 10, 2016, confirmed that it was the home's expectation that incidents that could be detrimental to the health and well-being of the resident were to be immediately reported to the SDM. [s. 97. (1) (a)]

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 the resident's Substitute Decision Maker (SDM) was immediately notified of an alleged, suspected or witnessed incident of abuse or neglect of a resident that caused distress to the resident that could have potentially been detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Dining observation of the meal service on an identified Resident Care Area revealed a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) removed dirty dishes and proceeded to serve the next entree to residents without performing hand hygiene.

Interview with the RPN shared that they were not aware that hand washing was required when removing dirty dishes and serving the next course. Interview with the PSW shared that they carry a cloth around to wipe their hands but were too busy.

Record review on March 4, 2016, of the home's policy for "Hand Hygiene" number 6-41 dated October 20, 2014, revealed "moments when hand hygiene is necessary include: before and after preparing, handling, or serving food or medications."

Interview on March 3, 2016, with the Food Services Supervisor revealed that the registered staff in the dining room were responsible to ensure that proper hand washing technique was performed by staff serving food.

Interview on March 3, 2016, with the Director of Care confirmed that it was the home's expectation that staff practice hand hygiene and safe food handling processes. [s. 229. (4)]

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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

A critical incident occurred on a specified date, as reported by the home, involving an identified resident and a staff member. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved. Review of the Long-Term Care Homes Critical Incident System used to report incidents to the Director, failed to identify an amended report of analysis and follow-up actions related to the identified critical incident.

Interview with the Resident Care Coordinator on March 9, 2016, confirmed that the results of the abuse investigation undertaken were not reported to the Director. The Director of Care confirmed on March 9, 2016, that it was the home's expectation that the results of the abuse investigation were reported to the Director. [s. 23. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home provided the resident with eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Observation of the residents' diets and special needs binder during the dining observation on a Resident Care Area revealed documentation that a specific resident was to use an assistive device for their meals. Observation by the Inspector revealed the resident was not provided with the assistive device.

Interview with a Registered Practical Nurse (RPN) revealed that the resident should have been given an assistive device because it helps them eat independently.

Interviews on March 3 and 4, 2016, with the Director of Care (DOC) and the Food Services Supervisor confirmed that it was the homes expectation that staff provided the resident with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

Issued on this 15th day of March, 2016

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

Original report signed by the inspector.