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
Jun 17, 2016	2016_259636_0007	010499-16	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

ANN POGUE (636)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 4, 5, 6, 2016

This critical incident inspection related to falls was done concurrently with Complaint #009529-16 and Complaint #011164-16

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), the Resident Care Coordinator (RCC), two Registered Nurse Team Leaders (TL), three Registered Nurses (RN) and one Registered Practical Nurse (RPN).

The inspector reviewed health records, policies, staff training records, and other relevant documentation. Observations were made in the home area.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that provided clear directions to staff and others who provided direct care to the resident.

An identified resident sustained numerous falls over the course of two months, one fall that resulted in hospitalization.

The staff members were interviewed, knew the resident's care needs, yet the information had not been documented such that all staff on all shifts knew the specific care needs for the identified resident.

The Resident Care Coordinator (RCC) reviewed the records and stated these observations and interventions were not identified in the care plan document and stated that is was an expectation that the care plan provided clear direction to staff that provide direct care to the resident.

The licensee failed to ensure that there was a written plan of care that provided clear directions to staff related to the risk of falls.

The scope of the issue was isolated to one resident. The severity of the issue was

determined to be a level two with potential for risk or harm to residents. The home did have a history of non compliance with this subsection of the regulation. It was issued as a voluntary plan of correction on June 9, 2015 (#2015_303563_0020), August 11, 2014 (#2014_229213_0052), May 20, 2014 (#2014_2635240017), Sept 3, 2013 (#2013_170203_0044), and July 16, 2013 (#2013_229213_0019. [s. 6. (1) (c)]

2. The licensee has failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

The plan of care for the identified resident indicated specific interventions for the resident, however these interventions had not been effective in reducing the number of falls. There was no documentation to support that different approaches were tried for the resident.

The Resident Care Coordinator (RCC) stated that the plan of care for the resident had been ineffective in minimizing falls or injury from falls and that it was an expectation that the care plan be updated on an ongoing basis, including the introduction of new interventions as appropriate. The RCC stated that different approaches had not been introduced for the resident related to fall prevention.

The licensee failed to ensure different approaches were considered in the plan of care when the resident was reassessed related to falls prevention.

The scope of this issue was isolated to one resident. The severity of the issue was determined to be a level two with potential for risk or harm to residents. The home had unrelated non-compliance in the last three years. [s. 6. (11) (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 ensuring that there is a written, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place was complied with.

The homes policy titled "Head Injury Routine", #h-10, last revised on October 19, 2012 indicated that registered staff will "begin Head Injury Routine immediately for residents who have had a fall and hit their head; or for residents who have a suspected head injury". The policy stated that "registered staff will do Head Injury Routine (HIR) for 24 hours: every 30 minutes for two hours, every two hours for twelve hours and every four hours for the remainder of twenty four hours". This information was to be recorded on the "Head Injury Routine" form.

An identified resident had several falls in which there was a suspected head injury. The Head Injury Routine (HIR) documentation for one fall was incomplete, and for another fall there was no documentation done by registered nursing staff.

The Resident Care Coordinator (RCC) reviewed the documentation with the inspector(s) and stated the documentation of the HIR was missing; the RCC stated there was an expectation that registered staff would have completed this assessment and documented it on the appropriate form.

The licensee failed to ensure that staff complied with the home's policy for Head Injury Routine for an identified resident when it was documented that a head injury did occur.

The scope of this issue was isolated to one resident. The severity of the issue was determined to be a level two with potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation that was issued as a voluntary plan of correction on July 9, 2015 (#2015_263524), April 27, 2015 (#2015_258519), May 20, 2014 (#2014_2635240017), May 8, 2014 (#2014_258519_0010), Nov 20, 2013 (2013_183135). [s. 8. (1) (a),s. 8. (1) (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 ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, and ensuring that if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that falls prevention and management training was provided to all staff who provided direct care to residents.

Staff training records were provided by Director of Care (DOC) on May 9, 2016, which indicated that 14% of staff had not completed the required training on falls prevention and management in 2015. Interview with DOC confirmed that it is an expectation that 100% of staff complete the required training for falls prevention and management.

The licensee has failed to ensure that training was provided to all staff who provide direct care to residents.

The scope of the issue was isolated to one resident. The severity of the issue was determined to be a level one with minimal risk to residents. The home had unrelated non-compliance in the last three years. [s. 221. (1) 1.]

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Issued on this 17th day of June, 2016

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

Original report signed by the inspector.