Ontario

Ministry of Long-Term Care	Ministère des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2020	2020_792659_0003	022908-19, 023577-19	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Waterloo
150 Frederick Street KITCHENER ON N2G 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

JANETM EVANS (659)

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): January 28, 29, 30 and 31, 2020.

The following intakes were included as part of this inspection:
Log #022908-19\Critical Incident (CI) M578-000050-19, related to a resident fall with transfer to hospital.
Log #023577-19\Critical Incident (CI) M578-000053-19, related to improper transfer of a resident, resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Assistant Managers of Resident Care (AMRC), Registered Practical Nurses (RPN), Wound Care Nurse, Personal Support Workers (PSW), and residents.

Observations of the provision of resident care, staff to resident interactions, logos and posting in resident rooms and a review of relevant clinical documentation was completed.

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

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	Légende 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out, the planned care for the resident related to the use of positioning aids.

Resident #002 used a power mobility device to assist them to mobilize independently on or off the unit.

On a specified date, resident #002 sustained an injury, when they were mobilizing.

Risk Management documentation showed resident #002 reported this incident to RPN #102, who assessed the resident but did not find any obvious injury. The RPN documented resident #002 had complained of discomfort during the assessment and that the resident's positioning aid had not been in place at the time of the incident.

A physiotherapist assessment documented there was no new visible injury following this incident.

A portable xray identified a injury.

Resident #002's care plan and kardex at the time of the incident, did not include the use of a positioning aid.

Resident #002 said that staff usually applied the positioning aid however on the day of the incident, the PSW forgot to do this.

PSW #103 said they found information about resident care in the kardex. They acknowledged that they had not applied the resident's positioning aid on the specified date. The PSW did not recall the application of the positioning aid being in resident #002's kardex at the time of the incident.

AMRC #104 said staff knew since August 2019, positioning aid was to be used for resident #002. The AMRC acknowledged that at the time of this incident, there was no documented intervention in the plan of care or Kardex for resident #002 related to use of the positioning aid.

The licensee had failed to ensure that there was a written plan of care for resident #002 that set out, the planned care for the resident related to the use of positioning aids. [s. 6. (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 there is a written plan of care for resident #002 and every resident, which sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.