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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 15, 2014	2014_229213_0052	L-000605-14	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

RHONDA KUKOLY (213)

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): August 12, 2014

This inspection was completed related to 4 critical incidents:
L-0006055-14
001186-14
002216-14
003049-14

During the course of the inspection, the inspector(s) spoke with 2 Acting Administrators, a Resident Care Coordinator, a Registered Nurse, a Registered Practical Nurse, 2 Personal Support Workers and 2 Residents.

During the course of the inspection, the inspector(s) made observations and reviewed health records, the home's internal investigation records, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

a) Staff interviews with a Personal Support Worker (PSW) and a Registered Staff member revealed that Resident #2 is to be bathed twice per week as well as specific information related to bathing for this Resident. Record review of the plan of care for Resident #2 revealed bathing information contrary to what the staff indicated.

b) Staff interview with the Resident Care Coordinator, a PSW and an Registered Staff Member revealed a specific intervention relating to bathing for Resident #2. No direction was found in the plan of care regarding this intervention.

c) Staff interview with the Resident Care Coordinator and the Acting Administrator revealed Resident #3 requires a particular intervention related to transferring. The Resident Care Coordinator confirmed that the shift routines are up to date and used by the PSW's when providing care. The record review of the plan of care for Resident #3 revealed it did not include this particular intervention.

d) The Acting Administrator confirmed that the plan of care related to bathing for Resident #2 and the plan of care related to transferring for Resident #3 did not provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that the provision of care set out in the plan of care,

the outcomes of the care and the effectiveness of the plan of care are documented.

a) Staff interviews with a Personal Support Worker (PSW) and a Registered Staff member revealed that Resident #2 is to be bathed twice per week. Review of the PSW shift routine confirmed Resident #2 is to be bathed twice per week. Review of Point of Care (POC) documentation for a 30 day period revealed Resident #2 had bathing completed on 2 particular dates and refused bathing on one particular date. No other documentation was found related to bathing in this Resident's health record for this 30 day period.

b) Staff interviews with the Acting Administrator and record review of the home's internal investigation records revealed Resident #3 did not have a particular intervention on a particular date. Record review of POC documentation for Resident #3 revealed documentation indicating this intervention was completed on this date. The Acting Administrator confirmed that the documentation reported that she documented in error.

c) The Acting Administrator confirmed that it is an expectation that care is provided for every Resident as per the plan of care and that all care provided is documented accurately in Point of Care by the staff member who provided the care or a reason for the absence of care and interventions taken documented in Progress Notes by the registered staff. [s. 6. (9) 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 each resident that sets out clear directions to staff and others who provide direct care to the resident and that the provision of care set out in the plan of care, the outcomes of the care and the effectiveness of the plan of care are documented, to be implemented voluntarily.

Issued on this 15th day of August, 2014

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