Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
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Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
Ottawa ON K1S 3J4
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Ontario

February 7, 2011

Mr. Kyle Cotton
Administrator
Sunnycrest Nursing Home
1635 Dundas Street, East
Whitby ON L1N 2K9

Dear Mr. Cotton:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on January 11, 2011 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely

Amanda Nix

Amanda Nixon
LTC Home Inspector – Dietary

c President, Resident's Council
President, Family Council

Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 11, 2011	2011_148_1013_10Jan081837	Complaint, Log # O-002264

Licensee/Titulaire
Sunnycrest Nursing Homes Limited, 1635 Dundas Street East, Whitby Ontario L1N 2K9
Fax 905-576-4712

Long-Term Care Home/Foyer de soins de longue durée
Sunnycrest Nursing Home, 1635 Dundas Street East, Whitby Ontario L1N 2K9
Fax 905-576-4712

Name of Inspector(s)/Nom de l'inspecteur(s)
Amanda Nixon (#148)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the diabetes care of an identified resident.

During the course of the inspection, the inspector spoke with the Administrator, Director of Resident Care Services, Assistance Director of Resident Care Services, Director of Dietary Services, Registered Nurse and Registered Practical Nurse responsible for care January 11, 2011 on the 3rd floor unit.

During the course of the inspection, the inspector reviewed the health care record of the identified resident including plan of care, Medication Administrator Records and Food and Fluid Intake records. The inspector also reviewed the homes Fall/Winter 2010/2011 menu and related policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication Administration
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8 s.6

(5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Findings:

1. As per the health care record of the resident, both the daughter and spouse, shared Power of Personal Care (jointly and severally). The health care record stated that the daughter was to be contacted first.
2. Interview on January 11, 2011 with the Director of Resident Care Services, stated that the resident was no longer able to make health care decisions and that the daughter and spouse of the resident were responsible for care decisions.
3. The daughter of the resident, informed the Ministry of Health and Long Term Care that the resident was provided with insulin, which she understood was no longer being provided, as it was put on hold.
4. A Care Conference was held where by both the daughter and spouse of the resident attended. Low blood sugars and the order for insulin were discussed.
5. The physician order, dated September 22, 2010, stated Lantus insulin was to be held until further reassessment.
6. The physician order, dated October 2, 2010, ordered Lantus and Novorapid insulin.
7. There was no documentation to support that either the daughter or spouse of the resident were given the opportunity to participate in the decision to change the resident's plan of care, as it relates to the provision of insulin.

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WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.131

(2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:

1. The physician order, for the resident dated September 8, 2010 stated "Lantus insulin 12 units sc q AM (if eating)" was to be administered at 0800 hours. The order was held September 22, 2010.
2. As per the Food and Fluid Intake record, the resident refused the breakfast meal on September 9, 2010. The Medication Administration Record, for that same day, indicated that Lantus insulin was held.
3. As per the Food and Fluid Intake record, the resident consumed 50% of breakfast on September 14, 2010. The Medication Administration Record, for that same day, indicated that Lantus insulin was held.
4. As per the Food and Fluid Intake record, the resident consumed 25% of breakfast on September 15, 2010. The Medication Administration Record, for that same day, indicated that Lantus insulin was provided.
5. As per the Food and Fluid Intake record, the resident refused breakfast on September 20, 2010. The Medication Administration Record, for the same day, indicated that Lantus insulin was provided.

Inspector ID #:	148

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
	Amanda Ndri LTCH Inspector
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). February 1, 2011