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
Feb 5, 2013	2013_203126_0006	O-001968-12,O-002432-12	Critical Incident System

Licensee/Titulaire de permis

SUNNYCREST NURSING HOMES LIMITED
1635 DUNDAS STREET EAST, WHITBY, ON, L1N-2K9

Long-Term Care Home/Foyer de soins de longue durée

SUNNYCREST NURSING HOME
1635 DUNDAS STREET EAST, WHITBY, ON, L1N-2K9

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 23, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, several Nursing staff and two residents.

During the course of the inspection, the inspector(s) reviewed two residents health care records, reviewed policy and procedures on Resident Rights abuse and neglect policy (P10) and observed care and services given to residents. During this inspection two Critical Incidents were reviewed.

The following Inspection Protocols were used during this inspection:
Medication

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, S. O. 2007, Chapter 8, S. 3. (1) 2. in that the home did not ensure that the following right of a resident was fully respected and promoted.

Resident #2 was not protected from staff abuse on a specific date in December, 2012. As a result of this incident, Resident #2 sustained an injury. [s. 3. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s.98 in that the home did not immediately notify the appropriate police force of an alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Resident #2 was not protected from staff abuse on a specific date in December 2012. As a result of this incident, Resident #2 sustained an injury.
The Administrator indicated to the Inspector that she had not been able to connect with the police regarding that incident.
Resident #2 indicated that she/he had not been interviewed by the Police as of January 23, 2013. [s. 98.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s.131. (2) in that the home did not administered a drug to a resident in accordance with the directions for the use specified by the prescriber.

In August, 2012, Resident #1 was not administered a medication/patch in accordance with the directions for the use specified by the prescriber.
The physician order was to administer the medication/patch in the morning and to removed the medication/patch at bed time. On a specific day in August 2012, while a registered staff was trying to take Resident #1 blood pressure, it was observed by the registered staff that Resident #1 had 2 medication/patches on one arm. The medication/patch was not removed as specified by the prescriber. [s. 131. (2)]

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Issued on this 5th day of February, 2013

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

L Harkness