Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 6, 7, 8, 17, Mar 6, 8, 9, 2012	2012_069170_0002	Complaint

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

DIANNE WILBEE (170)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Senior Services, Administrator of Resident Care, Resident Care Coordinators (3), Registered Nurse/Team Leader, Program Manager, RAI Documentation Coordinator, Registered Practical Nurse (2), Residents (2), Personal Support Worker, and Resident Home Assistant.

During the course of the inspection, the inspector(s) reviewed the following: Resident record, Policies and Procedures related to the inspection, Resident Incident Report, Staff position descriptions/routines, Residents' bath list, Weekly skin assessment schedule, Daily Flowsheets, Medication Administration Records, Residents' Council minutes, Staff schedule, and Resident/Client Registry - Coroner's Report.

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A resident fell and hit their head. The home did not ensure the following policies and procedures were complied with:
a) Head Injury Routine policy and procedure Number: h-10, Date of Last Review: November 17, 2009 as follows:
The policy and procedure identifies that head injury routine should begin "immediately for residents who have had a fall and hit their head or for residents who have a suspected head injury" and states the head injury routine is "to continue for 24 hours: every 30 minutes for 2 hours, every 2 hours for 12 hours and every 4 hours for remainder of 24 hours". After the resident fell neurological vital signs were taken once on the evening shift. Vital signs which included blood pressure, pulse and respirations were taken once on the night shift. No further vital signs or neurological assessments of the resident were documented.
b) Falls - Guidelines For Post Assessment and Care procedure Number f-03, Date of Last Review: January 24, 2011 as follows:
The procedure identifies under the following sections that "the registered staff will...2) avoid moving the resident until status has been evaluated; 12) document details of fall, assessment and results...". A Registered staff did not document post the resident's fall to indicate an assessment of the resident was completed prior to moving the resident; and details of the fall were not documented in the progress notes. Reference: O.Reg. 79/11, 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 to ensure at the time of a resident fall with impact to the head that staff comply with the requirements of the home's policies and procedures specific to Head Injury Routine and Falls Assessment, to be implemented voluntarily.

Issued on this 9th day of March, 2012

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

Dianne Thilbee #170