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*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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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
March 18 and 28, 2011	2011_170_9578_18Mar082019	Critical Incident L-00136

Licensee/Titulaire
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/Nom de l'inspecteur
Dianne Wilbee ID#170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to a resident fall.

During the course of the inspection, the inspector spoke with: Administrator Resident Care, Resident Care Coordinator, Registered Nurse (1), Registered Practical Nurse (1), Personal Support Workers (3), Manager of Administration Services.

During the course of the inspection, the inspector: Reviewed the home's investigation of incident, reviewed the resident's record, reviewed Policy number 7-10, reviewed call bell system related to emergency calls.

The following Inspection Protocols were used in part or in whole during this inspection:

- Critical Incident Response
- Prevention of Abuse, Neglect and Retaliation

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

2 WN
1 VPC

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(7)**
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:
A staff member did not provide care to a resident as set out in the plan of care resulting in the resident falling and sustaining an injury.

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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 an emergency call system for use in residents' washrooms is implemented to support identified resident care needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with **O.Reg. 79/10, s.107(4)3.v.**
A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

3. Actions taken in response to the incident, including,

v. the outcome or current status of the individual or individuals who were involved in the incident.

Findings:
The home did not amend a Critical Incident Report related to the current resident's status.

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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. Dianne Hilbert
Title: Date:	Date of Report: April 4, 2011