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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 17, 2016	2016_226192_0016	011164-16	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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 4, 5 and 6, 2016

This complaint inspection was completed concurrently with the following inspections:
Complaint 009529-16, IL-437690-LO
Critical Incident 008342-16, 008641-16 related to Critical Incident Report M578-000020-16
Critical Incident 007807-16, related to Critical Incident Report M578-000017-16 and Critical Incident 010499-16, related to Critical Incident Report M578-000021-16.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care, Resident Care Coordinators, Team Leaders, and Personal Support Workers.

The inspector reviewed medical records, incident reports, bed assessment records, and Policy and Procedure.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Review of the plan of care and interview with Team Leader #102 confirmed that resident #001 used two quarter bed rails at all times.

Review of the medical record and interview with a Substitute Decision Maker (SDM) confirmed that there had been a request for a change in bed rails used for resident #001.

Review of the medical record identified that resident #001 sustained falls from bed during a specified period in 2016. Documentation and interview with Team Lead #102 identified that resident #001 had intervention for fall prevention in place.

Record review and interview with Resident Care Coordinator (RCC) #101 confirmed that the bed used by resident #001 had been assessed for entrapment risk in December 2015.

Interview with RCC #101 confirmed that resident #001 had not been assessed for their safety in the bed with quarter bed rails in place, in spite of the family request for a change in the bed rails, falls from the bed, and the routine use of two quarter bed rails for resident #001.

The licensee failed to ensure that resident #001 who routinely used two quarter bed rails, was assessed for their safety in a bed with bed rails in place. [s. 15. (1) (a)]

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 ensuring that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

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Issued on this 17th day of May, 2016

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

Original report signed by the inspector.