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 prévue 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 soins de longue durée

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 7, 2019	2018_508137_0029	023641-18	Critical Incident System

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

MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 21-22 and 26-28, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager Resident Care, Resident Care Coordinators, Registered Practical Nurse and Personal Support Worker.

The Inspector also observed resident care provision and fall prevention interventions, reviewed resident clinical records, internal investigative records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified was protected from neglect by the

licensee or staff.

Ontario Regulation 79/10 s.5 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident that caused injury to an identified resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The identified resident sustained a fall and expressed discomfort. A review of the plan of care indicated the resident was to be routinely toileted at specified hours. The identified staff member did not follow the plan of care for the resident, as the internal investigation showed that the resident was not toileted as scheduled. There was no documented evidence that an identified registered staff member treated the resident for pain management or directed oncoming staff not to move the resident, due to a potential injury.

A second registered staff member was notified at the time of the fall but internal investigative records showed a delayed response to assess the resident. When the resident was assessed, the resident demonstrated signs of pain. There was no documented evidence that the registered staff member notified the on-call physician, treated the resident for pain or directed oncoming staff not to move the resident, due to a potential injury.

A third registered staff member checked the resident for Head Injury Routine (HIR) but there was no documented evidence of any additional assessments completed. The identified resident exhibited signs of pain and discomfort. There was no documented evidence that the registered staff member assessed the resident, aside from the head injury routine. The resident did not receive pain management in a timely manner; nor were staff provided clear direction not to move the resident.

A fourth registered staff member was informed that the resident had fallen with potential injury. There was no documented evidence that the registered staff member attempted to contact the family, notified the on-call physician, provided clear direction to staff regarding the resident's care or provided pain management in a timely manner.

During an interview, the Resident Care Coordinator (RCC) said that they conducted the internal investigation and the evidence gathered showed that there was a pattern of inaction by the registered staff involved, that jeopardized the health and safety of the identified resident.

The licensee has failed to ensure that the identified resident was protected from neglect by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2018_508137_0029
Log No. / No de registre :	023641-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 7, 2019
Licensee / Titulaire de permis :	Regional Municipality of Waterloo 150 Frederick Street, KITCHENER, ON, N2A-4J3
LTC Home / Foyer de SLD :	Sunnyside Home 247 Franklin Street North, KITCHENER, ON, N2A-1Y5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Julie Wheeler

To Regional Municipality of Waterloo, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA.

Specifically the licensee must:
Ensure that residents are protected from neglect by the licensee or staff, as outlined in the LTCHA, 2007 S.O. 2007, c.8, s. 19(1), of the Long Term Care Home Act.
Ensure that when a resident falls, action is taken including the following steps:
-an assessment of the resident
-notifying the physician
-pain management interventions, if clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that an identified resident was protected from neglect by the licensee or staff.

Ontario Regulation 79/10 s.5 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident that caused injury to an identified resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The identified resident sustained a fall and expressed discomfort. A review of the plan of care indicated the resident was to be routinely toileted at specified hours.

The identified staff member did not follow the plan of care for the resident, as the internal investigation showed that the resident was not toileted as scheduled. There was no documented evidence that an identified registered staff member treated the resident for pain management or directed oncoming staff not to move the resident, due to a potential injury.

A second registered staff member was notified at the time of the fall but internal investigative records showed a delayed response to assess the resident. When the resident was assessed, the resident demonstrated signs of pain. There was no documented evidence that the registered staff member notified the on-call physician, treated the resident for pain or directed oncoming staff not to move the resident, due to a potential injury.

A third registered staff member checked the resident for Head Injury Routine (HIR) but there was no documented evidence of any additional assessments completed. The identified resident exhibited signs of pain and discomfort. There was no documented evidence that the registered staff member assessed the resident, aside from the head injury routine. The resident did not receive pain management in a timely manner; nor were staff provided clear direction not to move the resident.

A fourth registered staff member was informed that the resident had fallen with potential injury. There was no documented evidence that the registered staff member attempted to contact the family, notified the on-call physician, provided clear direction to staff regarding the resident's care or provided pain management in a timely manner.

During an interview, the Resident Care Coordinator (RCC) said that they conducted the internal investigation and the evidence gathered showed that there was a pattern of inaction by the registered staff members that jeopardized the health and safety of the identified resident.

The licensee has failed to ensure that the identified resident was protected from neglect by the licensee or staff. [s. 19. (1)]

This area of non-compliance was determined to have a severity level of three, actual harm/risk, the scope was a level one, isolated, and compliance history of

four, despite Ministry of Health (MOH) action non-compliance continues, related to the current area of concern.

The home does have a history of non-compliance in this subsection of the Legislation.
It was issued as a:
Written Notification and Compliance Order on June 12, 2017, under Inspection # 2017_418615_0017, during a Critical Incident System (CIS) Inspection;
Written Notification and a Voluntary Plan of Correction on May 26, 2016, under Inspection #2016_457630_0017, during a Critical Incident System (CIS) Inspection.

(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

Service Area Office /
Bureau régional de services : Central West Service Area Office