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
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 18, 2019	2019_798738_0006	004252-18, 005416-18, 005646-18, 006436-18, 009626-18, 011593-18, 013412-18, 015115-18, 017140-18, 026699-18	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

AMANDA OWEN (738), 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): March 19-22 and 25-26, 2019.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Log #011593-18, CIS #M578-000032-18, Log #017140-18, CIS #M578-000041-18, Log #015115-18, CIS #M578-000038-18, Log #013412-18, CIS #M578-000035-18, Log #005416-18, CIS #M578-000020-18, related to alleged abuse and responsive behaviours;
Log #004252-18, CIS #M578-000013-18, related to alleged neglect;
Log #006436-18, CIS #M578-000017-18, Log #005646-18, CIS #M578-000014-18, related to medication;
Log #009626-18, CIS #M578-000029-18, Log #026699-18, CIS #M578-000059-18, related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Coordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The inspectors also toured the home, observed resident care provision, staff to resident interactions, resident to resident interactions, reviewed residents' clinical records, relevant policies and procedures and internal investigation records.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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	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 resident #004 was protected from neglect by the licensee or staff in the home.

The following is further evidence to support the order issued on January 7, 2019, during a CIS inspection 2018_508137_0029 to be complied January 31, 2019.

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 CIS report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident that caused injury to resident #004 for which the resident was taken to hospital and which resulted in a significant change in the residents’ health status.

Record reviews and staff interviews showed that resident #004 sustained an injury after they were left unattended by PSW #116. The records also showed that the PSW failed to assist the resident to prepare for a specified activity of daily living and did not ensure that interventions to maintain the resident's safety were implemented as outlined in their plan of care.

During an interview, RCC #125 said they conducted the internal investigation and the evidence gathered showed that there was inaction by PSW #116 that jeopardized the health and safety of resident #004.

The licensee has failed to ensure that resident #004 was protected from neglect by the licensee or staff in the home. [s. 19. (1)]

2. The licensee has failed to ensure that residents #007 and #008 were protected from

abuse by the licensee or staff in the home.

Ontario Regulation 79/10 s. 2 (1) defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

i) The home submitted a CIS report to the MOHLTC, related to an incident that caused physical injury to resident #007.

Record reviews and staff interviews showed that staff observed an altercation between resident #007 and #009 in which resident #007 sustained an injury.

Record reviews and staff interviews showed that resident #009 had a history of responsive behaviours directed toward other residents.

During an interview, RCC #100, acknowledged that resident #007 was harmed by resident #009 during an altercation.

ii) The home submitted a CIS report to the MOHLTC, related to an incident that caused physical injury to resident #008.

Record reviews and staff interviews showed that staff observed resident #008 say something hurtful to resident #007. Resident #007 responded by being physically responsive resulting in an injury to resident #008.

Record reviews and a staff interviews showed that resident #007 had a history of being physically and verbally responsive toward other residents.

During an interview, RCC #100 and RN #122, acknowledged that resident #008 was injured as a result of an altercation with resident #007.

The licensee has failed to ensure that residents #007 and #008 were protected from abuse by the licensee or staff in the home. [s. 19. (1)]

Issued on this 26th day of April, 2019

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

Original report signed by the inspector.