

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport No de l'inspection

Sep 23, 2020

Inspection No /

2020 750539 0014

Loa #/ No de registre

004887-20, 008620-20, 010116-20, 010170-20, 011408-20, 012643-20, 014757-20, 015982-20, 016637-20, 017939-20, 018073-20

Type of Inspection / **Genre d'inspection**

Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Waterloo 150 Frederick Street KITCHENER ON N2G 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

VALERIE GOLDRUP (539), AMANDA OWEN (738)

Inspection Summary/Résumé de l'inspection



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durée

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

This inspection was conducted on the following date(s): September 8, 9, 10, 2020.

The following intakes were inspected in this inspection:

Log #: 004887-20, CIS#M578-000030-20, related to an unexpected death.

Log#: 008620-20, CIS#M578-000043-20, related to incompetent treatment.

Log# 010116-20, CIS#M578-000047-20 and Log# 014757-20, CIS#M578-000056-20 related to alleged abuse and neglect.

Log #: 010170-20, CIS#M578-000048-20, Log #: 015982-20, CIS#M578-000059-20, and Log #: 016637-20, CIS#M578-000061-20 related to falls prevention and management.

As well, the following intakes were completed in this CIS Inspection:

Log #: 011408-20, CIS#M578-000050-20, Log #: 012643-20, CIS#M578-000054-20, Log#: 017939-20, CIS#M578-000064-20, Log #: 018073-20, CIS#M578-000066-20 related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Care/ Director of Care (DOC), Assistant Managers of Care, Registered Practical Nurses (RPNs), a Physiotherapist, a Recreation Therapist and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection: **Falls Prevention Hospitalization and Change in Condition Personal Support Services** Prevention of Abuse, Neglect and Retaliation



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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	Légende
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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non- respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.



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WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

- s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c.
- 8, s. 24 (1), 195 (2).
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants:

1. The licensee has failed to ensure that any person that had reasonable grounds to suspect that improper care had occurred, that resulted in risk of harm to a resident by a staff member, immediately reported the suspicion and the information upon which it was based to the Director.

A staff member was alleged to have improperly cared for a resident where there could have been harm. The incident was reported to a registered staff the day it occurred, however, it was not reported to management until the next day, at which time it was reported to the Director.

There was no harm to the resident and the resident did not appear affected by the staff member's actions.

The home failed to immediately report the alleged improper care of the resident by staff to the Director.

Sources: Critical Incident Report #M578-000056-20, the home's investigative records, and staff interviews. [s. 24. (1)]



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Issued on this 24th day of September, 2020

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

Original report signed by the inspector.