Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 18, 2023	
Inspection Number: 2023-1585-0007	
Inspection Type: Critical Incident System	
Licensee: Regional Municipality of Waterloo	
Long Term Care Home and City: Sunnyside Home, Kitchener	
Lead Inspector Mark Molina (000684)	**Inspector Digital Signature**
Additional Inspector(s) JanetM Evans (659) Josee Snelgrove (674) Kailee Bercowski (000734) Nuzhat Uddin (532)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-11 and 14-15, 2023
The inspection occurred offsite on the following date(s): August 16, 2023

The following critical incident intakes were inspected:
- Intake: #00022933 - related to restraints
- Intake: #00085187 - related to staff to resident verbal/emotional abuse
- Intake: #00086442 and Intake: #00089473 - related to staff to resident neglect
- Intake: #00087406 - related to plan of care
- Intake: #00090392 - related to improper medication administration
- Intake: #00091734 - related to a resident fall resulting in injury
- Intake: #00092150 - related to improper care of a resident resulting in injury

The following intake(s) were completed in this inspection:
- Intake: #00090051 - related to a resident fall

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from neglect when they were left unattended on the toilet for a period of time.

Ontario Regulation 246/22 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.

Rationale and Summary
A resident was left on the toilet for a period of time without assistance.

The PSW said another staff member was not sent in to provide the required care for the resident when they left the room.

The resident was not provided with the required assistance for care.

Sources: Resident’s clinical records; Interviews with resident, and staff.
[674]

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WRITTEN NOTIFICATION: Compliance With Manufacturers' Instructions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee failed to ensure that staff used a fall prevention device in accordance with the manufacturer's instructions.

Rationale and Summary
A resident was assessed to require a fall prevention device. Their plan of care directed staff to ensure the fall prevention device was in place and in working order every shift.

The resident had a fall and the device was not in place as per the manufacturer's instructions. As a result, staff were not informed that the resident was on the floor.

Failing to ensure that the manufacturer's instructions were followed, resulted in delayed staff awareness that the resident required assistance.

Sources: Resident's clinical records; Home's investigation; Fall Prevention Equipment Guide; Interviews with staff.
[659]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
The resident's plan of care directed staff to complete a transfer in a specific way.

A staff member observed a PSW completing a transfer, not in accordance with the resident's plan of care.

The PSW said they did an incorrect transfer with the resident, despite knowing the correct transfer method.

Failing to ensure safe transferring techniques were used when transferring the resident, put both the resident and staff at risk of injury.

Sources: Resident's clinical records; Home's investigation; Interviews with staff.
[659]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to implement strategies that were developed for a resident when they displayed responsive behaviours.

Rationale and Summary
A resident's care plan documented that they were to receive as needed (PRN) medication when they displayed responsive behaviours.

The resident was displaying responsive behaviours during care with staff; therefore, care was unable to be provided. A registered staff said it would have been appropriate to administer PRN medications at the time for the resident's behaviours, but medication was not administered. The following day, the resident was found in a condition where they still required care.

By not implementing the strategies to support the resident with their responsive behaviours, the resident did not receive the care they required.

Sources: Interviews with staff; Resident's clinical records.
[000684]

WRITTEN NOTIFICATION: Medication Management System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

A) The licensee has failed to comply with their written policies and protocols that were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of drugs used in the home when a staff administered medication to a resident, but did not follow their policy.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure written policies and protocols were developed for the medication management system, and they must be complied with.

Specifically, staff did not comply with the home's policy on a medication preparation through a specific route.

Rationale and Summary
A resident had responsive behaviors.

A registered staff administered medication for the responsive behaviours, but did not prepare the medication as per the home's policy.

The registered staff said that they did not follow the procedure because they did not want to trigger any further behaviours for the resident.

By not following the home's medication administration policy, the resident may not have received the full dose of the medication, which may impact the resident's behaviours.

Sources: Interviews staff; Resident's clinical record; Home's medication administration policy

B) The licensee has failed to comply with their written policies and protocols that were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of drugs used in the home when the registered staff administer medication but did not follow the home's policy on medication administration.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure written policies and protocols were developed for the medication management system, and they must be complied with.

Specifically, staff did not comply with the home's medication administration policy utilizing best practice standards.

Rationale and Summary
The resident was assessed for pain and responsive behaviours.

The resident had an order of a medication, and the registered staff did not administer the medication as per the home's medication administration policy.

The registered staff said that they did not follow the proper process of medication administration, as they did not want to trigger any further behaviors for the resident.

The registered staff breached infection control procedures and did not provide medications in accordance with the home's policy, which may have had a negative impact on the resident's safety and well-being.

Sources: Interviews staff; Resident's clinical record; Home's medication administration policy
[532]