Ontario

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

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

Central West District
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Original Public Report

Report Issue Date: February 12, 2024

Inspection Number: 2024-1585-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Regional Municipality of Waterloo

Long Term Care Home and City: Sunnyside Home, Kitchener

Lead Inspector	**Inspector Digital Signature**
Janis Shkilnyk (706119)	Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2024.02.16 06:43:46 -05'00'

Additional Inspector(s)
Diane Schilling (000736)
Brittany Nielsen (705769)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 24-26, 29-31, 2024 and February 1, 2024

The following intake(s) were inspected:

- Intake: #00093761 / Intake: #00105166 related to disease outbreak
- Intake: #00096705 - Fall of resident with injury
- Intake: #00101841 / Intake: #00102994 related to complaints to the home of improper care of a resident

- Intake: #00102210/ Intake: #00102653 related to a complainant of improper care of a resident
- Intake: #00105329 / Intake: #00107656 - related to a complaint regarding the resident's bill of rights
- Intake: #00107103 - Intake: #00107421 - related to an allegation of resident abuse.

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that

the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that all chemical cleaning agents and disinfectants used for cleaning high touch surfaces were appropriately labelled.

Rationale and Summary

Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, recommended all chemical cleaning agents and disinfectants should be appropriately labelled.

It was observed that there were bottles of blue liquid unlabeled in the housekeeping cart on two resident home areas.

Staff stated that the bottle contained a disinfectant but that the label always comes off. The Housekeeping manager stated that they were aware that the labels do not

adhere to the bottles and that staff were to put a new label on when needed and that the new labels were available on the bulletin board if they need replacing.

It was observed that all bottles of disinfectant were labelled in the housekeeping cart.

Sources:

Observations of housekeeping carts, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, interviews with staff.

[000736]

Date Remedy Implemented: January 24, 2024

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee has failed to ensure staff followed the home's Responsive Behaviour Protocol following a resident's escalating responsive behaviours as required.

As per O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place and protocol, the licensee was required to ensure that the protocol was complied with.

The home's Responsive Behaviour Protocol stated upon identification of escalating or new physically responsive behaviours, the Team Leader, registered nurse (RN) would complete an unusual occurrence report, consult the assistant manager of care (AMOC), initiate Dementia Observation Screening (DOS) charting for seven days, and refer the resident to the Behavioural Support Ontario (BSO) team.

Rationale and Summary

A resident's responsive behaviours towards other residents escalated. Registered staff working at the time was notified of the incidents. In response the Registered staff did not complete the required tasks as per the Responsive Behaviours Protocol.

By failing to follow the home's Responsive Behaviour Protocol, the required referrals and interventions were not put in place in a timely manner.

Sources:

interviews with staff and record review of a resident clinical records and the home's Responsive Behaviour Protocol

[705769]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

The home submitted a Critical Incident (CI) report to the Director reporting allegations of abuse from a resident towards other residents. The allegations of abuse were reported to registered staff but not to the management of the home.

Assistant Manager of Care (AMOC) acknowledged that the incidents should have been reported to the Director immediately.

By failing to report the allegation of abuse immediately, the home was unable to complete an internal investigation and implement interventions to prevent any further incidents from happening.

Sources:

interview with staff and record review of a critical incident and a resident's progress notes.

[705769]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The license failed to ensure when a resident fell, they were assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument.

Rationale and Summary

A resident had an unwitnessed fall.
As part of the post fall assessment, staff were expected to conduct a head-to-toe assessment prior to transferring the resident post fall.

Staff did not conduct a head-to-toe assessment prior to transferring a resident off the floor after the fall.

Later that evening, the resident was transferred to hospital with injury.

The Assistant Manager of Care stated that a full body assessment should have been completed for the resident and its delay may have delayed the diagnosis and treatment for the resident.

Sources:

A resident's clinical record, interview with staff, policy Falls Prevention and Management Program #f-02, revised August 25, 2023.

[000736]

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee failed to monitor a resident's responses to, and the effectiveness of pain management strategies.

In addition, in accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to comply with their pain management policy.

Rationale and Summary

A resident experienced a fall and was initially observed not to experience pain after falling.

The home's Pain Management policy # p-12, revised August 1, 2023 stated that a pain assessment should be completed when pain is not relieved by initial interventions and/or if the family stated the resident was in pain and if administration of as needed (PRN) pain medication was ineffective the registered staff should notify the physician.

The resident was administered as medication for complaints of pain. The documentation indicated this was not effective to control the resident's pain, and they were given their regularly scheduled analgesic. There was no pain assessment completed for the resident after this time.

The resident later had pain and was transferred to hospital for assessment.

Assistant Manager of Care stated that the effectiveness of analgesia administered for pain to a resident was not assessed after having been administered and that the home's pain policy had not been followed by staff.

When the resident did not have the effectiveness of pain medication monitored and assessed, they experienced prolonged pain and treatment was delayed.

Sources:

clinical record of a resident, interviews with staff

[000736]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented. Specifically, they failed to ensure staff wore the appropriate Personal Protective Equipment (PPE) when providing care to residents and residents with additional precautions.

Rationale and summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long Term Care Homes, revised September 2023, stated that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. Section 9.1(f) Additional Precautions at a minimum, documented PPE requirements including appropriate selection application, removal and disposal by staff.

Staff were observed with their surgical masks incorrectly on three occasions in the same area of the home.

A staff was observed wearing PPE inappropriately.

IPAC coordinator stated that all staff should be wearing masks properly in resident areas at all times. They confirmed that not wearing PPE appropriately could increase the risk of infection transmission.

Failure to don the appropriate PPE in the home and for additional precautions when caring for the residents may have increased the potential risk for spread of infectious disease pathogens.

Sources:

IPAC observations, interviews with staff, IPAC Standard for Long Term Care Homes, revised September 2023

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WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in

accordance with directions for use specified by the prescriber when a resident did not receive their prescribed medication.

Rationale and Summary

A medication was prescribed by the physician for a resident. The drug was put on hold without an order from the prescriber.

Registered staff stated that they had changed the resident's electronic medication record (EMAR) to indicate the medication should be held. The registered staff stated that a prescriber order should be obtained when a medication is held for a resident.

The home's failure to ensure that a resident received medication as directed by the prescriber may have led to a potential impact to the resident's health status.

Sources:

Review of a resident's clinical records, electronic medication administration record (EMAR), interview with staff.

[706119]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon,

every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident involving a resident, was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Summary and Rationale

A resident received medication that had been discontinued.

The Director of Care (DOC) stated a medication incident report was not completed for the medication error and should have been.

When the home did not complete a medication incident report for a resident there was a missed opportunity for the home to review causative factors and staff follow up related to the incident.

Sources:

Home's medication incident policy, review of a resident clinical records, interview with DOC.

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