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

Original Public Report

Report Issue Date: July 4, 2024

Inspection Number: 2024-1585-0003

Inspection Type:
Critical Incident

Licensee: Regional Municipality of Waterloo

Long Term Care Home and City: Sunnyside Home, Kitchener

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2024.07.05 11:37:45 -04'00'

Additional Inspector(s)
Julia Boakye-Ansah (000862)
Jasneet Ahuja (000865)
Eunice Dapaah (000861)
Janis Shkilnyk (706119)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 11-14, 18-20, and 24, 2024.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
-Intake: #00115242, and Intake: #00115768, related to an allegation of improper / incompetent care of a resident;
-Intake: #00116170, related to an allegation of resident abuse;
-Intake: #00116897, related to an injury of a resident that required transfer to the hospital, resulting in a significant change in health status.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's adaptive aide was functioning as per the plan of care.

Rationale and Summary
A resident was prescribed an adaptive aide at a specified level to assist with comfort and prevent skin breakdown.

The residents' device was not functioning for a period of time and when the staff completed an assessment on the resident they had new areas of altered skin integrity.

The Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) acknowledged the device was not functioning as per the plan of care. The Assistant Manager of Care (AMOC) stated that the equipment had been disconnected from the device.

Failing to ensure that the plan of care was followed negatively impacted the resident when they were assessed to have altered skin integrity after they were lying on a device that was not functioning.

Sources: Care plan, Documentation survey report v2 April 2024, interviews with PSW, RPN, and AMOC.
[000861]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to reassess and update the plan of care for a resident when their care needs changed.

Rationale and Summary
A resident sustained an injury at the home that required additional assessment, and treatment at the hospital.

A PSW, RPN, and the AMOC stated they referred to the care plan to identify the care needs of a resident.

The AMOC stated the resident's injury caused a functional change in status for the resident and their care plan was not reviewed or revised to address the changes.

By not reviewing and revising the resident's care plan when their care needs changed, staff were not made aware of the revised care needs of the resident.

Sources: Interviews with PSW, RPN's, and AMOC, review of resident's clinical records, policy s. 50 Skin and Wound Program, revised May 2023.
[706119]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to protect a resident from sexual abuse by another resident.

For the purpose of this Act and Regulation, "sexual abuse" means any non-

consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
A PSW witnessed resident A touch resident B. Resident B was reported to be to be upset and agitated and pointing at resident A immediately following the incident.

At the time of the incident, resident B was scheduled to have one to one staff to monitor them; however, they were not present when the incident occurred.

Sources: Resident care plan and progress notes; interviews with PSW, Registered Nurse (RN), AMOC, and the homes investigation notes.
[000862]

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the improper or incompetent treatment or care of a resident that resulted in harm, or a risk of harm to the resident, was reported to the Director immediately, as required.
Rationale and Summary

An RN discovered that there had been no re-assessment or treatment of a residents' altered skin integrity for four months.

The home's Professional Practice Lead confirmed they became aware that treatment had not been provided for this four month period, but did not report it to the director until two weeks later.

By not immediately reporting the suspicion of alleged risk of harm to the resident, the Director was unable to respond immediately.

Sources: Critical Incident System (CIS) report and Professional Practice Lead. [000865]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by an authorized person, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A resident sustained an acute injury that resulted in altered skin integrity.

The home's Wound Care Nurse confirmed that the resident had not had an initial skin and wound assessment completed. The home's process was to use a skin and wound application to document a picture of the area and complete an assessment of a resident's initial alteration to their skin integrity.

The home's failure to complete an initial skin and wound assessment for the resident may have impacted their treatment.

Sources: Residents clinical records, interviews with Wound Care Nurse [706119]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The home failed to ensure that a resident was assessed by a registered dietitian when they had an alteration in skin integrity as required.

Rationale and summary
A resident sustained and injury that resulted in altered skin integrity. A dietician referral or assessment was not completed at the time of the incident.

The home's Registered Dietician (RD) stated that they had not received a dietary referral for the resident at the time of the incident, and had not assessed their nutritional status until close to one month later.

When an RD referral was not completed for an acute injury resulting in altered skin integrity, the RD was not able to provide a nutritional assessment or interventions which may have had an impact on the healing process.

Sources: Review of resident's clinical record, interview with RD.
[706119]

COMPLIANCE ORDER CO #001 Doors in a home

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 4.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
4. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must be compliant with O. Reg. 246/22 s. 12 (1) 4

Specifically, the licensee must:

A) Consult with the local fire department to ensure compliance with the Ontario Fire Code related to locks on resident's bedroom and bathroom doors (bathroom doors within a resident room). Update the home's fire safety plan and the planned monthly fire drills to include the responsibility of staff to release the locks on resident room doors or bathroom doors as required. Ensure that the homes' process is documented and the communication of the process with the local fire department is retained to support this process as a whole.

B) Conduct an audit of all resident bedroom and resident bathroom doors, (bathroom doors within a resident room) to determine which doors have locks on them. Document the type of lock on each door and a determination as to whether the locks are readily releasable from the outside in an emergency. Record the date of the audit, the name and designation of the person conducting the audit, and any corrective actions taken.

C) If a key or other such device is implemented in order to ensure a lock on a door is readily releasable from the outside, document the type of key/device that is required to release the lock on the audit document.

D) Implement a written policy and procedure for all staff in all departments to follow, where a lock on a resident bedroom door or bathroom door remains in place, that will ensure the lock can be readily released in the event of an emergency. Ensure that the policy and procedure is communicated to all staff and that a record of how this was communicated to all staff is kept in the home. The communication should include the date it was communicated, the method it was communicated and who received the communication.

E) Update the orientation training and annual retraining program to include the policy and procedure regarding locks on resident room doors and resident bathroom doors and maintain records to support that the education has been provided.

Grounds
The licensee has failed to ensure that any locks on resident bedrooms and washrooms within their rooms that lock, can be readily released from the outside in an emergency.

Rationale and Summary

A push button lock was observed on resident's bedroom doors.

A PSW stated they were unaware that resident bedroom doors locked and were not aware how to unlock resident bedroom doors in case of an emergency.

The Director of Care stated they were unaware that resident bedroom doors throughout the home locked. Upon further investigation the home realized resident washroom doors within the residents' room also locked.

When the home did not have a process to ensure resident bedroom and washroom doors could be readily released from the outside, residents were at risk for not being monitored and receiving staff assistance in an emergency.

Sources: Observations and interviews with DOC, PSW #106.
[706119]

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #002 Skin and wound care

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must be compliant with O. Reg. 246/22 s. 55(2)(b)(iv)
Specifically, the licensee must:

A) Review and revise the home's skin and wound care program policy to incorporate best practice guidelines, the addition of assessments of surgical wounds, and step-by-step processes for the following:
i) When, how, and who will complete initial altered skin integrity assessments and what assessment tool is to be used;
ii) When, how and who will complete weekly altered skin integrity assessments and what assessment tool is to be used. For pressure injuries and wounds: ensure to include that the assessment information required, should align with best practice guidelines;
iii) Where staff are to document the assessments;

iv) Processes for referrals to other disciplines for altered skin integrity as required;
v) Instruction to all registered staff, skin and wound lead and AMOC on the use of the home's wound care application in its entirety;
vi) Process for ensuring that weekly skin and wound assessments will be completed and tracked. The process must include guidelines for discontinuing resolved altered skin and wound impairments.

B) Complete position descriptions for the skin and wound Lead and the home's designated wound care nurses.

C) Provide all registered staff, including Assistant Managers of Care, and Skin and Wound Lead, education on the home's revised skin and wound management program policy, and ensure that the education includes identifying and reporting altered skin impairments, conducting comprehensive skin and wound assessments, and developing a treatment plan for altered skin integrity.

D) Document the education completed in part A), and C) including the date education was completed, format and staff attending the training, including the person who provided the education.

E) Complete weekly wound assessments for residents specified residents following the homes reviewed and revised skin and wound care policy.

F) Conduct weekly audits of those residents with altered skin integrity to ensure that registered staff are completing initial and weekly assessments as per the home's revised skin and wound care program policy. The audits should continue for one month or until such time as compliance is achieved. Written documentation of the audits including the person who conducted the audits, what was reviewed in the audits, the date the audits were conducted, the outcome of the audits, and

corrective actions taken, and the audits must be kept in the home.

Grounds
The licensee failed to ensure that two residents' areas of altered skin integrity were reassessed at least weekly by an authorized person.

The home's "Skin and wound care program", policy # s-50, revised May 2023, stated all new altered skin integrity required a skin assessment with pictures. The pictures were to be taken using the skin and wound care application and documented in point click care (PCC), initially, and as part of the weekly skin inspection.

Rationale and Summary
A) A resident had altered skin integrity. Their weekly skin assessments were not completed in full and were missing clinical assessment information.

The AMOC confirmed that weekly wound assessments for a resident had not been completed as required, and they would expect to see measurements and photos of the wound weekly.

Sources: Review of a resident's clinical records, interview with AMOC, policy-Wound and Skin Care Program, policy # s-50, revised May 2023.
[706119]

Rationale and Summary
B) A resident had altered skin integrity and had not had any weekly wound assessments completed for four months.

The home's Skin and Wound Lead acknowledged that the residents weekly wound assessments should have been completed as per the home's policy.

Both residents were at greater risk of wound deterioration when their weekly wound assessments were not completed, and the registered staff were not assessing the progression of healing on a weekly basis.

Sources: Review of a residents weekly wound assessments, interview with Professional Practice Lead, Skin and Wound Lead and policy-Wound and Skin Care Program, s-50, revised May 2023.
[000865]

This order must be complied with by September 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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