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:** September 26, 2024
**Inspection Number:** 2024-1585-0004
**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Regional Municipality of Waterloo
**Long Term Care Home and City:** Sunnyside Home, Kitchener

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 5, 6, 9-13, 17-20 and 23, 2024

The following intake(s) were inspected:
- Intake: #00118469, Intake: #00124581 related to resident fall resulting in injury.
- Intake: #00119430 related to improper care of resident resulting in injury.
- Intake: #00119737 related to staff to resident abuse.
- Intake: #00120613 related to allegation of resident abuse resulting in injury
- Intake: #00121789 related to allegation of resident abuse
- Intake: #00121846, Intake: #00123371 related to medication administration
- Intake: #00121854 related to improper care of residents
- Intake: #00122781, Intake: #00123256 related to care concerns of a resident

The following intakes were completed:
- Intake: #00119587 related to resident fall resulting in injury.

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

Continence Care
Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and 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)**
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 failed to ensure that a resident was protected from abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

**Rationale and Summary**

A resident approached and grabbed a co-resident causing an injury.

Failing to ensure co-resident was protected from abuse resulted in an injury.

**Sources**: Incident report, resident progress notes, resident assessments, interviews with Registered Nurse (RN) and Assistant Manager of Care (AMOC).

## WRITTEN NOTIFICATION: Dress

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 44**
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their

own clean clothing and in appropriate clean footwear.

The licensee failed to ensure that a resident was dressed appropriately.

**Rationale and Summary**

A resident was brought into the dining room without proper clothing.

Family of the resident visited and expressed concern related to how the resident was dressed. Family told staff the resident was embarrassed.

Interviews with the RN and AMOC acknowledged that the resident was not dressed appropriately at the time they were placed in the dining room.

Not appropriately dressing the resident resulted in a negative emotional impact to the resident and was disrespectful to their dignity and bill of rights.

**Sources**: Incident report, resident progress notes and care plan, interviews with PSW, RN and AMOC.

## WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 54 (1)**
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the

review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to implement the use of equipment for prevention and management of falls for a resident.

**Rationale and Summary**

A resident was at at high risk for falls. The plan of care included use of equipment to decrease the risk of injury related to falls.

The resident fell and suffered an injury. The equipment was not in place at the time of the fall.

The AMOC and staff acknowledged the equipment was not in use at the time of the fall, and it should have been.

**Sources**: Incident report, falls prevention and management program, Scott Falls risk, resident's plan of care, interview with AMOC and staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (1) 4.**
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum,

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provide for the following:
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.

The home failed to implement strategies for a resident to maintain continence when equipment was not available for the resident.

**Rationale and Summary**

A resident had alteration to their skin integrity and used an assistive device for elimination.

Staff instructed the resident to use their incontinent product for elimination. The resident was incontinent and emotionally upset.

The AMOC stated equipment was not readily available and acknowledged that the resident was emotionally upset from the incident.

When equipment was not available to ensure a resident was able to maintain continence, the resident was emotionally impacted and had potential worsening of their altered skin integrity.

**Sources**: Review of resident clinical record, interview with resident and AMOC

## WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (1)**
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:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required.

The licensee has failed to comply with their responsive behavior program when a resident exhibited a new or worsening, high risk responsive behavior.

In accordance with O. Reg. 246/22 s. 11. (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.

Specifically, the home did not comply with the licensee's policy, Responsive Behavior Program. The policy stated when a resident's responsive behaviour was determined to be high risk, new or worsening, staff were to notify the Medical Doctor/Nurse Practitioner, consult with the Assistant Manager of Care/standby

manager, inform the substitute decision maker and assign a code white pendant. When the situation was determined to be stable staff were to complete risk management, complete the Confusion Assessment Method (CAM) and update the plan of care.

**Rationale and Summary**

A resident exhibited a worsening responsive behavior towards staff, and again towards another resident days later.

The AMOC stated the resident's worsening responsive behaviour was high risk and had been known to occur on other occasions, and acknowledged the responsive behavior program policies had not been implemented.

There was potential risk of harm to residents when staff did not implement all procedures related to the resident's escalating, new and/or high-risk responsive behaviour at the time it was observed.

**Sources**: Review of resident clinical record, interviews with AMOC, Registered Practical Nurse (RPN), PSW, review of Responsive Behavior Program policy.

## WRITTEN NOTIFICATION: Administration of drugs

NC #006 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 failed to ensure that a medical therapy was administered to residents in accordance with the directions for use specified by the prescriber.

**Rationale and Summary**

A) A resident was ordered a medical therapy, along with guidelines for monitoring of its effectiveness.

Over a four month period the resident's family voiced concern related to the therapy administration.

The RN verified concerns related to the resident's therapy, and stated there was no ill effect to the resident.

The AMOC acknowledged the concerns related to the resident's prescribed therapy.

Failure to ensure the resident received their required therapy in accordance with directions for use as per the prescriber, put the resident at risk for other health concerns.

**Sources**: Incident report, resident progress notes, plan of care, eMAR, weights and vitals, home's investigation, interviews with AMOC and staff.

B) A resident had a history of a disease and was ordered a medical therapy, including guidelines for monitoring of its effectiveness.

On several occasions the required guidelines for the therapy were not met as per the prescriber's orders.

The RN acknowledged there had been concerns related to the resident's prescribed therapy and that there had been therapy administration problems. The RN indicated without the therapy the resident demonstrated ill effects.

Failing to ensure the resident received their medical therapy in accordance with the prescribers orders put the resident at risk for negative health effects.

**Sources**: Complaint, progress notes, plan of care, interviews with interim AMOC and RN

C) A resident was being provided with a medical therapy for palliation.

An observation showed that the resident was not receiving their prescribed therapy.

The RPN acknowledged that the resident did not have their prescribed therapy being administered, and should have.

Failure to ensure the resident received their medical therapy as prescribed put the resident at risk for negative health effects.

**Sources**: observation, plan of care, eMAR, interviews with AMOC and RPN