Ontario

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2020	2020_792659_0008	002585-20, 002777-20, 003136-20, 003278-20	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

JANETM EVANS (659), VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 11, 12 and 13, 2020.

The following intakes were completed in this inspection:
Log #002585-20\Critical Incident M578-000019-20 related to an incident with injury.
Log #002777-20\Critical Incident M578-000022-20 related to alleged abuse and neglect.
Log #003136-20\Critical Incident M578-000024-20 related to alleged abuse and neglect.
Log #003278-20\Critical Incident M578-000025-20 related to an incident with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MOC), Assistant Managers of Resident Care (AMOC), a Staff and Admin Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

The Inspectors toured the home and observed dining service. Resident care, services and activities were also observed. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 was followed with respect to provision of all personal care.

A Critical Incident was submitted to the Ministry of Long Term Care (MLTC) related to alleged neglect of resident #001.

The clinical records for resident #001 documented the resident required assistance with all Activities of Daily Living (ADLs).

A Behavior Support Ontario (BSO) binder for 1:1 care for resident #001 kept at the nursing station listed the 1:1 responsibilities for staff related to personal care and engagement of the resident.

On a specified date, RPN #111 was assigned to complete 1:1 care with resident #001. On that same date, PSW #109 observed the resident had not received all their personal care and assistance as per the 1:1 role. They spoke to RPN #111 who verbalized that they had not understood that their 1:1 responsibilities included the provision of all personal care for resident #001. The PSW reported their concern to RN #110 that resident #001 had not received assistance with their personal care.

RN #110 said all staff were aware of the 1:1 roles and responsibilities for this assignment. RN #110 spoke with the RPN, who said they assisted the resident with their meal, but they had not provided all personal care to resident #001.

The home's investigation found that the resident had not been provided assistance with all personal care as per the 1:1 role.

The licensee failed to ensure that plan of care for resident #001 was followed with respect to the provision of ADL and personal care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff will follow the plan of care for resident #001 and meet all of their ADL and personal care needs. In addition to this, the licensee will ensure that all staff are aware of the roles and responsibilities for 1:1 care of all residents, and where they can locate this information when they complete a 1:1 assignment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1), and in reference to s.52. (2) the licensee was required to ensure that the home had a pain management program to identify pain in residents and manage pain.

Specifically, staff did not comply with the licensee's pain management policy, p #12, revised September 12, 2016, which was part of the licensee's pain management program. This policy stated that for new or uncontrolled pain, staff were to administer analgesics according to Medical Directives or PRN doctor's orders when a resident

reported pain, demonstrated behavioural changes or other possible signs of discomfort related to pain. If administration of medical directive pain medication was ineffective, the physician was to be notified.

Resident #002 had a history of pain in specified areas. They mobilized independently without the use of mobility aides.

Review of the electronic Medication Administration Record (eMAR) showed twice daily pain screening was completed. There was a medical directive for a specified analgesic medication to be given every four hours as needed for pain or fever up to a total of three doses.

Daily pain screening was completed for a specified 12 day period, which showed the resident's pain level fluctuated from zero to moderate pain.

Resident #002's clinical records within a specified three day period, documented the resident had increased difficulty mobilizing and with pain. On a specified date, documentation stated resident #002 screamed with the provision of care. EMAR documentation showed the administration of the specified medical directive was ineffective. This was the third dose of the medical directive analgesic.

Two pain assessments (PAINAD) were completed in a specified nine day period, which documented moderate pain. On one specified date, it documented severe pain.

Resident #002 continued to be administered the specified analgesic from the medical directive one to two times per day over a five day period.

RN #117 said they had not been aware that resident #002 had received more than three doses of the medical directive analgesic. The RN said the physician should have been notified when three doses of the analgesic had been administered so that other medication could have been ordered for pain management.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any program the program, was complied with, specific to following the home's pain management program. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's pain management policy, which is part of the pain management program will be followed for all residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #002 in accordance with the directions for use specified by the prescriber.

A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) on a specified date, which documented a fracture of unknown cause for resident #002.

Review of clinical records for resident #002 documented they had increased difficulty with mobilizing and increased pain.

Review of resident #002's Medical Directive eMAR from a specified one month period, showed documentation of a medical directive for the administration of a specified analgesic every four hours as needed (prn) for three doses. Documentation on the eMAR showed the resident had been administered 11 doses of the specified analgesic over an eight day period.

RN #117 said they were only to administer the specified analgesic for three doses and they had not been aware that resident #002 had received more than three doses of the specified analgesic.

AMRC #103 acknowledged the resident had received more doses than had been prescribed and that staff had not followed the physician's order.

The licensee has failed to ensure that that drugs were administered to resident #002 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to all residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.