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 Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date August 16, 2022
Inspection Number 2022_1585_0002
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Regional Municipality of Waterloo

Long-Term Care Home and City
Sunnyside Home, Kitchener

Lead Inspector
Helene Desabrais (615)

Choose an item.

Helene Desabrais
Digitally signed by Helene Desabrais
Date: 2022.08.16 08:21:35 -04'00'

Additional Inspector(s)
Jessica Bertrand (722374)
Josee Snelgrove (674) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 14, 15, 16, 17, 22, 23, 27 and 28, 2022.

The following intake(s) were inspected:

Intakes #009548-21, #013443-21, #019054-21, #020302-21, #001144-22, #003816-22, #009076-22 related to falls prevention;
Intakes #010318-21, #016377-21, #017879-21, #017901-21, #002307-22, #006539-22 related to unexpected death;
Intakes # 004539-22 and #011585-22 related to prevention of abuse, neglect, and retaliation.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION - TRANSFERRING AND POSITIONING TECHNIQUES

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s.40

The licensee has failed to ensure that when staff transferred a resident, they used safe transferring techniques.

After a resident's fall, a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) manually transferred the resident from the floor to a chair.

The home's Falls Prevention and Management Program policy, stated in part, that when a fall occurs, the registered staff were to provide instructions to PSWs to use a mechanical lift to transfer residents from the floor.

A PSW and the Director of Care both stated that the home's process was to use a mechanical lift to transfer a resident after a fall. In this incident, staff did not use a mechanical lift as per the home's process.

The staff's failure to use safe transferring and positioning devices to transfer the resident after a fall posed a risk of further injuries to the resident.

Sources: Resident's progress notes, post-fall assessment, home's Falls Prevention and Management Program" policy (last revised January 23, 2019), interviews with a PSW, the Assistant Manager of Care, the Fall Lead and DOC.

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WRITTEN NOTIFICATION – DUTY TO PROTECT

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 24(1).

The licensee has failed to ensure that a resident was protected from abuse by anyone.

"Physical abuse" is defined as the use of physical force by anyone other than a resident that causes physical injury or pain. O. Reg. 256/22. S. 2 (2) (a).

The home's investigation stated that while providing care, a PSW witnessed another PSW be aggressive and rough with a resident by forcibly with them. The PSW said the resident seemed frightened and had redness on their skin following the incident.

The resident's care plan interventions directed staff to allow the resident time to respond to questions, read their body language and respond to the feelings they were trying to express. If the resident resists with an activity of daily living, reassure, leave and return five to 10 minutes later and try again. These techniques were not used during the provision of care to the resident during the incident.

The PSW admitted their wrongdoing during the home's investigation. The DOC acknowledged that the resident did sustain reddened marks on their skin as a result of the rough care.

Sources: The home's CIS report, the home's investigation, a resident's clinical records, interviews with an RN, a PSW, a RT and DOC.

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WRITTEN NOTIFICATION - FALLS PREVENTION AND MANAGEMENT

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 54(2).

The licensee has failed to ensure that when a resident fell, they received a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident had a fall and was found on the floor by a Personal Support Worker, who then notified a Registered Practical Nurse (RPN). The resident's progress notes, stated in part, that they were found with injuries The post-fall assessment documented the resident suffered "some pain". The post fall assessment was incomplete as Range of Motion (ROM) of the extremities was not fully conducted. Later, the resident received a follow-up assessment which indicated the resident had a bruise on their body and presented with facial grimacing upon turning and repositioning. A range of motion was not completed for the resident.

At a later date, the resident experienced increasing pain during care. A Registered Nurse noted that the resident's left leg was shortened and externally rotated. The resident was then sent to the hospital and diagnosed with a fracture.

The DOC stated that the resident did not receive a complete assessment after their fall.

The RPN's failure to fully assess the resident after the fall may have delayed the diagnosis and treatment of their injuries.

Sources: A resident's progress notes, post-fall assessments and interviews with a PSW, the Fall Lead and DOC.

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COMPLIANCE ORDER #001 – REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#04 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021, s. 28(1)2.

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The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021, s. 28(1)2.

The licensee shall:

a)Ensure that the PSW receives re-education and coaching related to their duty to immediately report certain matters to the Director.

b)Ensure the home has a process for responding to incidents of abuse, and that the PSW is provided education on this process including how to intervene when an incident of abuse is occurring.

c)Document the education, as outlined in a) and b), including the date, format and the staff member who provided the education.

Grounds

Non-compliance with: FLTCA, 2021, s. 28(1)2.

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. Pursuant to s.154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

The home submitted a Critical Incident (CI) to the Director reporting allegations of physical abuse from a Personal Support Worker (PSW) to a resident resulting in injury. The home's CI stated that the PSW, who witnessed the abuse, did not report the incident to management or the Director until the next day.

The Director of Care stated that the incident should have been reported immediately to the Director.

The staff's failure to immediately report the abuse resulted in risk of harm to the resident, as they were not immediately assessed for their injuries and emotional well-being, and the staff member accused continued to provide care to residents.

Sources: The home's CIS report, the home's investigation, the home's policy Resident Abuse and Neglect Zero Tolerance (last revised April 6, 2021), the resident's clinical records, interviews with a PSW, an RN and the DOC.

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This order must be complied with by August 29, 2022

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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.

- 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
email: 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.