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: May 3, 2023	
Inspection Number: 2023-1585-0006	
Inspection Type: Critical Incident System	
Licensee: Regional Municipality of Waterloo	
Long Term Care Home and City: Sunnyside Home, Kitchener	
Lead Inspector Janis Shkilnyk (706119)	**Inspector Digital Signature** Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2023.05.04 10:51:52 -04'00'
Additional Inspector(s) Yami Salam (000688) Kaitlyn Puklicz (000685)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 25, 26, 27, 28, 2023

The following intake(s) were inspected:

- Intake: #00018975 - allegations of staff to resident abuse.
- Intake: #00020603 – allegation of resident abuse.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

The licensee has failed to ensure that a resident's rights were fully respected and promoted when a resident's right to refuse treatment was not respected by staff.

Rationale and Summary

Staff offered to provide care to a resident. The resident refused.

A staff member said that despite the resident's refusal, another staff member attempted to provide care which resulted in the resident becoming emotionally distressed.

The resident reported to a staff member they were upset with the care provided.

As a result of this incident, there was a risk of harm to a resident when their right to refuse care was not respected.

Sources: Critical incident, a resident's electronic records, home's internal investigation and interviews with a resident and staff.

[000688]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that an allegation of abuse related to a resident was reported to the Director immediately.

Rationale and Summary

A resident reported an allegation of abuse. The home reported the allegation to the Director late.

A staff member stated the allegation should have been reported to the director as soon as staff had become aware.

The home's failure to report to the Director immediately after becoming aware of an allegation of resident abuse, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Critical Incident Reporting System (CI), clinical record review for a resident, interview with staff.

[000685]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, was completed.

Rationale and Summary

A resident had an alteration in skin integrity identified. A staff member said an initial skin assessment should have been completed. A skin assessment was not completed.

The home's failure to complete an initial skin and wound assessment for the resident when an alteration in skin integrity was identified could have impacted treatment and thus the healing of the skin condition.

Sources: Resident's clinical records, interview with staff, policy-Resident Care Services Manual Skin and Wound Care Program, revised April 2021.

[000685]