Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2017	2017_263524_0029	025881-17	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF WATERLOO
150 Frederick Street KITCHENER ON N2A 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

INA REYNOLDS (524), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 20, 21, 22, 23 and 24, 2017.

The following intakes were completed within the RQI:
Log #008844-17 Follow-up to Compliance Order #001 related to policy.
Log #024713-17 / CIS M578-000054-17 related to Falls Prevention.
Log #024933-17 / CIS M578-000049-17 related to Falls Prevention.
Log #025183-17 / CIS M578-000051-17 related to Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care, two Resident Care Coordinators, three Team Lead Registered Nurses, six Registered Practical Nurses, seven Personal Support Workers, one Housekeeping staff, the Residents' Council Representative, the Family Council Representative, 20 residents and three family members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, medication administration, a medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, relevant policies and procedures of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2017_263524_0004	524

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	Legendé 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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The home provided 17 medication incidents for the time period of August to October 2017.

A review of three medication incident forms was completed with the Resident Care Coordinator (RCC).

The medication incident for an identified resident documented on a specific date and time, that the resident had ingested another resident's identified medication when it was

placed on the table for their table mate. The RCC stated they had not documented an assessment and vitals and acknowledged that the medication incident for the resident was not documented, together with a record of the immediate actions taken to assess and maintain the resident's health. In addition the RCC acknowledged that the home had not documented notification to the prescriber of the drug and the resident's attending physician.

Review of the medication incident for another identified resident showed on a specific date and time, that the resident was administered more medication than prescribed. Review of the document provided showed that a page appeared to be missing that included who was notified of the medication incident.

During an interview, the RCC and Manager of Resident Care stated they were unable to provide documented evidence as to who was notified of the medication incident for this resident.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

A review of a medication incident for an identified resident showed on a specific date and time, that the resident was administered more medication than prescribed. A review of the medication incident showed that the second page was missing which was where the home would have included the root cause analysis and corrective action documented.

During interviews with the RCC and Manager of Resident Care, they acknowledged that they were unable to provide documented evidence that analysis of the incident and corrective action was documented.

The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

The scope of this area of non-compliance was isolated and the severity was determined to be minimum risk. The home had no related non-compliance in the last three years. [s. 135. (2)]

Issued on this 1st day of December, 2017

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

Original report signed by the inspector.