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

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Original Public Report

Report Issue Date: February 2, 2023	
Inspection Number: 2023-1585-0005	
Inspection Type: Critical Incident System	
Licensee: Regional Municipality of Waterloo	
Long Term Care Home and City: Sunnyside Home, Kitchener	
Lead Inspector Kristen Owen (741123)	**Inspector Digital Signature** Kristen A Owen Digitally signed by Kristen A Owen Date: 2023.02.08 10:15:29 -05'00'
Additional Inspector(s) Janis Shkilnyk (706119) Kaitlyn Puklicz (000685)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 5-6, 9-11, 2023

The following intake(s) were inspected:

- Intake: #00012777, Intake: #00015039, and Intake #00015563 related to fall prevention and management of residents.
- Intake: #00015573 related to the medication management of a resident.
- Intake: #00016364 related to prevention of abuse and neglect, and responsive behaviours.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Medication Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that clear direction was provided to staff and others who provide direct care to the resident when a resident did not have the correct transfer logo that was consistent with the resident's care plan and kardex.

Rationale and Summary
A resident had an unwitnessed fall in their room that resulted in an injury. Upon return from hospital, the resident was assessed to require a different method of transfer. During the inspection, a transfer logo was observed on the head of the resident's bed that indicated the incorrect transfer method.

The Safe Resident Handling Program Goals and Objectives policy directed registered staff to ensure the correct transfer logo was in place in the resident's room and was identified in the resident's plan of care.

A Personal Support Worker (PSW) stated that a change in lift status for a resident was made aware to other staff by their kardex and the transfer logo located on the resident's bed. A Registered Practical Nurse (RPN) stated the resident's care plan, kardex and bed logo should always match for their method of transferring. The RPN confirmed the transfer logo that was on the head of the resident's bed, was not the resident's correct transfer method at the time of inspection.

The resident's care plan and kardex documented the resident's correct method for transfers. An Assistant Manager of Care (AMOC) stated that when a resident's lift logo changes, their care plan and logo on their bed should be updated.

The RPN changed the logo on the resident's bed to the correct transfer method during the inspection.

There was potential risk of harm to the resident when their transfer logo was not clearly and consistently identified, as staff may not have been aware of the update in the resident's plan of care and transferred the resident incorrectly.

Sources: Interviews with staff, review of the resident's clinical record and care plan, Safe Resident Handling Program Goals and Objectives policy, section-safe client handling, revised June 23, 2022, and the Critical Incident report.

Date remedy implemented: January 5, 2023

[706119]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure drugs were administered to a resident in accordance with the directions for use specified by the prescriber, when a resident was not provided with their ordered medication from September 2022 to December 2022.

Rationale and Summary
On a day in September 2022, a resident attended a specialist appointment and returned to the home with a prescription for medications. The prescription was not transcribed or dispensed from the pharmacy until a day in December 2022. The resident did not receive the medication.

The Critical Incident (CI) report documented that the resident did not receive the ordered medications that were prescribed on an identified day in September 2022, until the error was discovered on an identified day in December 2022.

An AMOC stated the resident's medication order was not processed or received from the pharmacy. A Registered Nurse (RN) stated that the process for completing medication orders was not followed when the resident returned from their specialist appointment with their prescription.

In December 2022, a note from the Specialist documented a change in the resident's condition, given the resident's time off the medication.

There was actual harm to the resident from not receiving the medication as ordered by the Specialist as the resident felt unwell and had a change in condition during the time that they were not receiving the prescribed medications.

Sources: Interviews with staff and the resident, review of the resident's clinical records, the Critical Incident report, and the documented note from the Specialist on an identified day in December 2022.

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WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1

The licensee has failed to comply with their fall prevention and management program when a resident was transferred from floor to bed after a serious injury was suspected.

In accordance with O. Reg. 246/22 s. 11. (1) (b), the licensee shall ensure that any actions taken with respect to a resident under a program, including relevant procedures, provides for methods to reduce risk and monitor outcomes, where required, and is complied with.

Specifically, the home did not comply with the licensee's policy, Falls Prevention and Management Program. The policy stated if serious injury was ruled out and it was safe to move the resident, the resident could be transferred to a comfortable place using the mechanical lift. Limb deformity was included as a suspected serious injury.

Rationale and Summary
A resident had an unwitnessed fall in their room on an identified date, that resulted in an injury.

The resident's progress notes documented the resident was found on the floor with pain and a rotated and shortened limb. An RPN stated the resident was not able to move and it looked like they had an injury. An RN said residents were not supposed to be lifted if there were injuries.

An AMOC said the resident was considered to have had a serious injury and should not have been moved from floor to bed with a mechanical lift unless there had been immediate danger identified.

There was potential risk of harm to the resident when staff suspected they had a serious injury and moved them from the floor to their bed using a mechanical lift, post fall.

Sources: Interviews with staff, review of the resident's clinical records, the Critical Incident report, and Falls Prevention and Management Program policy, revised February 22, 2022.

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