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: November 10, 2022	
Inspection Number: 2022-1585-0004	
Inspection Type: Critical Incident System	
Licensee: Regional Municipality of Waterloo	
Long Term Care Home and City: Sunnyside Home, Kitchener	
Lead Inspector Helene Desabrais (615)	**Inspector Digital Signature** Helene Desabrais Digitally signed by Helene Desabrais Date: 2022.11.15 14:24:11 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 27, 31, November 1, 2 and 3, 2022.

The following intake(s) were inspected:

-Intake #00002046/Critical Incident Report (CI), intake #00006432/CI and intake #00011840/CI related to falls prevention;

-Intake #00008041/CI related to prevention of abuse, neglect and retaliation;

-Intake #00009112/CI related to medication.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION [ADMINISTRATION OF DRUGS]
NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with Ontario Regulation (O.Reg.) 79/10 s.140(2).

The licensee has failed to ensure that a resident was administered a medication in accordance with the directions for use specified by the prescriber.

Rational and Summary

The home's physician ordered an initial dose of a medication once a day for a resident. Six days later the home's physician increased the dose of the medication. For 20 days the resident continued to receive the initial dose of the prescribed medication and the resident continued to experience specified symptoms.

The home's "Medication Administration and Documentation" policy, last reviewed August 15, 2018, directed the registered nurses that all medication must be administered to residents according to the directions for use specified by the Prescriber. The policy also directed the registered nurses to take appropriate steps to resolve and report medication incidents that occurs at any point in the process of prescribing, compounding, dispensing, administrating, or documenting a medication.

For a period of 20 days, five Registered Practical Nurses continued to administer the initial prescribed dose of the medication to the resident and they took no steps to resolve and report the discrepancy.

An Assistant Manager of Care (AMOC) stated that the Registered Practical Nurses should have reported the discrepancy.

The failure to administer the correct dosage of the medication to the resident put the resident's overall heath at risk.

Sources: Resident's clinical records, Home's Critical Incident Report, home's Medication Administration and Documentation policy (last reviewed August 15, 2018), home's medication incident reports and interviews with a Registered Nurse and an AMOC.

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