Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 9, 2021	2021_792659_0001	025560-20	Critical Incident System

Licensee/Titulaire de permis

peopleCare Not-For-Profit Homes Inc.
735 Bridge Street West Waterloo ON N2V 2H1

Long-Term Care Home/Foyer de soins de longue durée

peopleCare A.R. Goudie Kitchener
369 Frederick Street Kitchener ON N2H 2P1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 13, 14 and 18, 2021.

The following intake was included for this inspection: Log #025560-20\Critical Incident (CI)#2990-000011-20, related to unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

Observations were completed for blood glucose monitoring, medication administration and storage. A review of relevant documents of was completed which included but was not limited to: policies and procedures, training records, plan of care, progress notes, and electronic medication records (eMARs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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).

Findings/Faits saillants :

1. The Licensee has failed to ensure that every incident of severe hypoglycemia for a resident was documented together with immediate actions taken to assess and maintain the resident's health. The Licensee also failed to ensure notifications were completed to the resident's Substitute Decision Maker (SDM), DOC, physician and pharmacy service provider, for every severe hypoglycemic incident involving two residents.

There were three recorded incidents of severe hypoglycemia, involving two residents, between December 2020 and January 2021. There was no documentation of notifications to the resident's physician, SDM, the DOC or pharmacy related to two of these incidents. There was no documentation of immediate actions taken to assess and maintain resident's health in relation to one of the severe hypoglycemic incident. The DOC acknowledged that not all of the home's documentation appeared to follow the requirements for severe hypoglycemic incidents

Not documenting incidents of severe hypoglycemia for residents and not completing required notifications for residents could prevent timely interdisciplinary assessment and interventions to manage the residents' health condition.

Sources : Residents' progress notes; electronic Medication Administration Record (eMAR); Home's policy: Hypoglycemia, 005140.00; interview with DOC [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every incident of severe hypoglycemia is documented, along with immediate actions taken o assess and maintain the resident's health. In addition to this they will ensure that all notifications are completed, including to the SDM, DOC, the resident's physician and pharmacy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 174.3, Directives by the Minister. Specifically, the licensee failed to comply with s. 174.1(3). Every licensee of a long-term care home shall carry out every operational policy directive that applies to the long-term care home.

The Minister's Directive: Glucagon, Severe Hypoglycemic, and Unresponsive Hypoglycemia, effective June 30, 2020, directed the licensee to ensure that all direct care staff receive training on the requirements of this Directive. In addition, the licensee was to document every incident of severe hypoglycemia or unresponsive hypoglycemia involving a resident, together with immediate actions taken to assess and maintain the resident's health and report the incident to the resident, Substitute Decision maker (SDM), DOC, Medical Director, the resident's attending physician and the pharmacy provider.

Between December 2020 to January 2021, there were three recorded incidents of severe hypoglycemia for two residents. There was no documentation that all required notifications were completed for two of the three incidents of severe hypoglycemia. There was no documentation of immediate actions taken to assess and maintain the resident's health for one of the severe hypoglycemic incident. A staff member said they had not received training on the Minister's Directives until after the incidents of severe hypoglycemia. Training on the Minister's Directives had not been completed by June 30, 2020, for all direct care staff.

The risk of not educating on the Minister's Directive related to severe hypoglycemia is that staff would not understand the requirements for providing timely proactive interdisciplinary assessment, treatment and follow-up documentation, posing a risk to the resident's health.

Sources : Residents' progress notes, eMAR, blood glucose; Minister's Directive : Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, dated February 13, 2020, effective June 30, 2020; training of the home's policy Hypoglycemia, 005140.00; interviews with a registered staff and DOC [s. 174.1 (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all direct care staff are trained on the Minister's Directive: Glucagon, Severe Hypoglycemic, and Unresponsive Hypoglycemia, to be implemented voluntarily.

Issued on this 18th day of February, 2021

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

Original report signed by the inspector.