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 East District
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Original Public Report

Report Issue Date: August 15, 2024
Inspection Number: 2024-1147-0002
Inspection Type: Critical Incident
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Hope Street Terrace, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10-12, July 15-19, 2024.

The following intake(s) were inspected:
- three intakes regarding falls that resulted in an injury.
- two intakes regarding resident-to-resident physical abuse.
- one intake regarding an allegation of unlawful conduct by staff that resulted in harm/risk of harm to a resident.
- one intake: regarding the use of a medication to a resident that resulted in a resident being transferred to hospital.

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee shall ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating a residents' blood sugar was low. The resident received a medication, and their blood sugar was rechecked however when there was no improvement in the residents' blood sugar, a second dose of medication was given. After two doses of the medication and no improvement in the resident's condition, Emergency Services was called, and the resident was transferred to hospital.

Review of the residents' clinical record indicated, the Physician ordered a residents' medication to restart, and the resident's blood sugars to be checked. The residents' blood sugars were checked during the seven days, and the residents' Physician

increased the resident's dose of the medication. After seven days, the blood sugar check ended. The residents' clinical records indicated a few weeks later the Nurse Practitioner (NP) assessed the resident and ordered their blood sugar checks twice a day for seven days.

The Registered Nurse (RN) agreed when the Physician orders ended, after the seven days, the nursing staff should have communicated with the Physician for further orders.

The NP reported when the residents blood sugar checks ended after seven days it was the nurses who communicated this to the ordering Physician and if the Physician was not available then the covering NP would be contacted for further orders.

The resident may have been at an increased risk for a hypoglycemic event when there was no communication by the nursing staff to the Physician indicating the blood sugar checks had ended.

Sources: A resident's clinical records, Interviews with the RN and NP.

WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (4) (a)

Air temperature

s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,

(a) every day during the period of May 15 to September 15.

The Licensee has failed to ensure that, for every resident bedroom in which air conditioning is not operational, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. every day during the period of May 15 to September 15.

Rationale and Summary:
During a tour of the home, it was observed that several resident rooms had window unit air conditioners installed but not operational due to residents' personal preference, and as indicated in the individual residents' plan of care who occupied the identified rooms.

A record review of the 2nd floor temperature logs indicated that only the following temperatures were recorded for the identified rooms from May 15 until July 11, 2024:
A room -June 11 temperature taken at 1400 hrs
A room -June 10 temperature taken at 1700 hrs, June 13 temperature taken at 1700 hrs, June 14 temperature taken at 1400 hrs , July 1 temperature taken at 1700 hrs, July 2 temperature taken at 1700 hrs
A room - temperatures were not taken

The Administrator and Director of Care acknowledged that the temperatures for several rooms were missing from May 15 until July 11, 2024 and they would expect staff to complete and document once a day in the afternoon between 12 p.m. and 5 p.m. every day during the period of May 15 to September 15, 2024.

There was an increase in risk to residents related to heat related illnesses when room temperatures were not monitored.

Sources: Interviews with Administrator, DOC, air temperature logs.

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)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The licensee has failed to ensure that a resident received skin assessment by a member of the registered staff and using a clinically appropriate instrument that is specifically designed for skin and wound assessment.

Rationale and Summary:

A CIR was submitted to the Director indicating a resident fell and sustained an injury and was transferred to hospital.

A resident had surgery to repair their injury, and returned home from hospital, with an incision. The residents' clinical record indicated a head-to-toe assessment upon their return however the assessment did not indicate they completed an assessment of the resident's wound using the home's clinically appropriate tool for wound assessments.

The home's policy for the Skin and Wound, indicates a resident exhibiting altered skin integrity, which may include, but is not limited to skin breakdown, and wounds, will receive a skin assessment by a Nurse using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A RPN agreed that a resident with a surgical wound should receive an assessment by the registered staff using the home's clinically appropriate tool designed for wound on a weekly basis.

The Inspector and the Director of Informatics (DOI) reviewed the Skin and Wound policy and the residents' impaired skin integrity assessments. The DOI reported when the resident returned from hospital, the clinically appropriate tool should have been used to assess the resident's surgical wound and the weekly impaired skin assessment. The DOI agreed the assessment was not completed as required for the residents' surgical wound.

The DOC further agreed upon the residents' return from hospital with a surgical wound, the registered staff did not complete the weekly clinically appropriate tool that was specifically designed for altered skin integrity.

When the residents' surgical wound was not assessed upon their return from hospital using the clinically appropriate tool, there would not be an initial wound assessment for the registered staff to reference, to assess if the wound was worsening or healing.

Sources: CIR, the home's policy, interviews with staff, DOI and DOC.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure a resident was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

Rationale and Summary:

A CIR was submitted to the Director indicating a resident fell, sustained an injury and was transferred to hospital.

Review of the resident's weekly skin integrity assessment for their surgical wound, indicated the reassessment was not completed weekly by the registered staff.

The Registered Practical Nurse (RPN), the DOC and (Director of Informatics) DOI, agreed the registered staff should have completed a weekly reassessment of the resident's incisional wound, using the home's clinically appropriate tool.

The resident may have been at an increased risk for a deteriorating wound when the wound was not reassessed weekly.

Sources: A resident's clinical records, interview with staff, the DOI and DOC.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented.

The licensee has failed to ensure a resident who was exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as surgical wounds, is assessed by a registered dietitian who is a member of the staff of the home, and

that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented.

Rationale and Summary:
A CIR was submitted to the Director indicating a resident fell and sustained an injury and was transferred to hospital. The resident returned to the home a few days later with a surgical incision.

A review of residents' clinical records indicated no Registered Dietitian (RD) referral was sent.

A review of resident's progress notes indicated the RD documented a nutritional note indicating the resident had no skin concerns.

The DOC and DOI Director agreed when the resident returned from home with a surgical wound a Dietary referral should have been made and an assessment by the Registered Dietitian should have occurred.

The home's Skin and Wound policy indicated to complete a referral to the RD, regarding surgical wounds. The RD will complete an assessment, document, and communicate to the interdisciplinary team any nutritional interventions to be implemented, and update the residents' plan of care as necessary.

The resident may have been at an increased risk for delayed wound healing when the resident was not assessed by the Registered Dietitian.

Sources: The home's policy, the resident's clinical records, interviews with the DOI and DOC.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure the monitoring of a residents' responses to, and the effectiveness of, the pain management strategies.

Rationale and Summary:
A CIR was submitted to the Director indicating a resident fell and sustained an injury was transferred to hospital. The resident returned home a few days later.

The home's policy indicated to complete a pain assessment for seventy-two hours on the day, evening shift and on nights only if the resident is awake for the following indications: when a new pain medication is started.

A review of the residents', clinical records, indicated that the resident had been ordered a new pain medication to manage their pain, upon their return from hospital. The resident was given the pain medication however there was no pain assessment completed as per the home's policy.

Five days later the residents' pain had increased, the Nurse Practitioner (NP) assessed the resident and ordered changes to the resident's pain medication to manage their pain.

A review of the residents' pain assessment indicated when the resident had new and worsening pain, a pain assessment was not completed.

The DOI and DOC agreed a pain assessment should have been completed for seventy-two hours when the resident was transferred back to the home from the

hospital, with a new pain medication order to manage their pain. The DOI and DOC further agreed no pain assessment was completed, when the resident had increased pain, and this assessment should have been completed.

When the registered staff did not complete a pain assessment, the effectiveness of the pain medication, the residents' response to the pain medication and the implementation of other strategies and referrals to manage their pain may have been missed.

Sources: The home's policy, a resident's clinical records, interviews with the DOI and DOC.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
4. Protocols for the referral of residents to specialized resources where required.

The licensee has failed to ensure that protocols for the referral of a resident to specialized resources are developed to meet the needs of a residents' responsive behaviors.

Rationale and Summary:
A CIR occurred involving a resident striking another resident and was transferred to the hospital.

The homes' Behaviour Policy indicated that the home was to establish community linkages to support the care of residents and refer the resident to a psychogeriatric

resource for further assessment and care planning if the resident is escalating despite interventions implemented, and, if the resident's behaviour is unpredictable, and places other residents or others at risk of harm.

The home had completed a referral to an outreach program that offers psychogeriatric services in February 2024, but the referral was not yet reviewed when the incident occurred. Following the incident on March 2024, the resident was transferred to the hospital, and the recommendation from the hospital Doctor, was made to transfer the resident to an inpatient program. In May 2024, a second incident occurred involving the same residents.

Interviews with the Behaviour Support Ontario (BSO) RPN and Director of Care (DOC) confirmed that after the resident was readmitted to the home, and immediately began to show responsive behaviors, the home did not re- apply to an outreach program and should have done so. During the inspection, the home applied to the outreach program.

Failure to refer a resident to a specialized program for geriatric mental health put the resident and others at risk of abuse.

Sources: CIR, the homes' policy, a residents' electronic health record, interviews with BSO RPN and DOC.

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents

and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that, procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who were harmed as a result of residents, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary:
A CIR occurred in May 2024 involving a resident striking another resident who then retaliated, with both residents suffering injuries.

A record review revealed:
- Behavioral Support Ontario (BSO) staff, was monitoring a resident since their admission for exit seeking tendencies.
- Both residents had a prior altercation on March 2024 and one resident was transferred to an inpatient program.
-A resident was readmitted to the home, a Dementia Observation Sheet (DOS) was initiated. The careplan was updated to include all interventions initiated during the inpatient program, such as the use of medications for restlessness and agitation.
-Both residents careplan did not include the other resident as a potential trigger.
- in May 2024, the DOS indicated that a resident exhibited exit seeking behavior on two occasions. Progress notes on that day indicate four documented entries of restlessness and agitation.
- in May 2024, a progress note, indicated angry behaviours regarding the noise of a residents' roommate. Later, a resident entered the room of another resident, and an altercation occurred and medications were administered for agitation and angry

behaviours.

During an interview with the BSO Registered Practical Nurse (BSO RPN), confirmed that they were unaware if any of the interventions to decrease restlessness, agitation and angry behaviours had been utilized, such as medications for angry/expressive behaviours.

During an interview with the BSO RPN, and the Director of Care, they confirmed that the home should have utilized interventions as indicated on the careplan for a resident, such as the use of medications for angry/expressive behaviours and increasing the staff presence when the resident began exhibiting signs of increased behaviors of restless, agitation and did not do so. New interventions were implemented following the incident, and a resident was provided a one-to-one Personal Support Worker (PSW) to monitor the resident twenty-four hours a day.

Ineffective behavioral management for a resident led to an increased risk of reoccurring incidents of physical harm towards another resident.

Sources: CIR, residents' clinical health records; interviews with BSO RPN and DOC.

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs are stored in an area or a medication

cart are secure and locked.

Rationale and Summary:
During a tour of the home, on floor #2, it was observed, that the medication and treatment carts were unlocked and the medication room door was open with no registered staff in the medication room.

Interviews with two Registered Practical Nurses (RPN) confirmed that the medication and treatment carts were unlocked and should be locked and the medication room door should also be locked when the registered staff are not working in the medication room.

Failure to ensure that the medication and treatment carts are kept secured and locked placed the residents at risk of harm.

Sources: Observations, Interviews with staff.

COMPLIANCE ORDER CO #001 RESIDENTS' DRUG REGIMES

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 146 (b)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(b) appropriate actions are taken in response to any medication incident involving a resident, any incidents of severe hypoglycemia and unresponsive hypoglycemia and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1. The DOC will complete separate comprehensive interviews with the two registered staff regarding a resident's hypoglycemic event. A documented record including the details of the meeting will be kept and made available to the inspector immediately upon request.

2. After the interview with the registered staff the DOC will request each staff provide a written reflection on what could have been done differently, to ensure the resident received appropriate interventions and monitoring.

3. The DOC will provide in person education to the Charge Nurse working regarding their roles and responsibilities as a Charge Nurse to support staff, and to assess resident's when their health condition is deteriorating. Keep a documented record of the education with RN 's signature and the date indicating what education was provided.

4. The DOC will review the home's Diabetic Management policy with the RPN. Keep a documented record of the policy that was reviewed with the RPN, including signature and date this education was completed.

Grounds
The licensee failed to ensure that appropriate action was taken in response to a resident medication incident involving a hypoglycemic event.

Rationale and Summary:
A CIR was submitted to the Director indicating a resident 's blood sugar was low. The resident received medication to increase their blood sugar. After two doses of this medication there was no improvement in the resident's condition, Emergency Services were called, and the resident was transferred to hospital.

The home's Diabetic policy provides the registered staff direction on how to manage a resident's blood sugar when it is low.

Review of the residents' clinical records indicated the resident's blood sugar was low and the RPN tried to administer the resident sugar, the resident took two spoon fulls orally and then resident refused to take any more. The RN was made aware of the situation and advised the RPN to continue to try to offer the resident oral glucose. At the end of the RPN's shift they tried to offer the resident some oral intake, however the resident was not able to ingest anything orally, and the residents' blood sugar was rechecked and the reading was lower, The RPN reported to the oncoming shift the residents' low blood sugar and refusal of oral glucose and the RN assessed the resident and administered a medication to increase the residents blood sugar. The residents blood sugar did not improve after the medication was administered and a second dose of the same medication was given. The resident's blood sugar (BS) did not improve after the second dose and the resident was transferred to hospital.

The RPN agreed the resident 's blood sugar was low, and they did not recheck their blood sugar as per the home's policy. The RPN acknowledged the resident should have been given a medication to increase their blood sugar when the resident was not able to ingest oral glucose, and their blood sugar was low. The RPN reported they had spoken to the RN that the resident's blood sugar was low, and that the resident would not take the oral glucose. The RPN reported they requested the RN give the resident a medication to increase their blood sugar, but the RN indicated to keep offering the resident oral glucose. The RPN reported the RN did not come up to assess the resident and they did not call the RN back until the end of their shift, and the residents' blood sugar was rechecked and had further dropped. The RPN was not aware they could administer a medication to increase the resident blood sugar.

The RN reported they were the RN in charge and agreed the RPN reported to them that residents had a blood sugar was low. The RN reported they advised the RPN to try to give the resident oral glucose to improve their blood sugar, and to call them back if it was not effective. The RN reported the RPN, called them again prior to the end of their shift to report the resident's blood sugar was lower and the oncoming RN went to assess the resident. The RN working that night with the RPN reported they were not sure if RPN's could give medication to increase a resident blood sugar and agreed they did not assess the resident.

The incoming RN received report about resident's condition and after assessing the resident they administered a medication to increase the resident's blood sugar. After two doses of this medication and no improvement in the resident's blood sugar the resident was sent to hospital.

In an interview with the DOC, they acknowledged the RPN did not check the residents' blood sugar as required. The DOC agreed that the home's policy was not followed to manage the resident's low blood sugar.

The resident's health was at an increased risk when the Charge Nurse did not assess the resident when the resident's blood sugar was low. The resident's health was further at risk when the RPN did not follow the home's policy, and this impacted the residents' health as there was a delay in the administration a medication and contacting Emergency services.

Sources: CIR, the home's policy, a residents' clinical records, interviews with staff and the DOC.

This order must be complied with by October 7, 2024

COMPLIANCE ORDER CO #002 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (b)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(b) corrective action is taken as necessary; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. The DOC or designate will provide in person training to all Registered staff, including agency staff working at the home the following:

a. How to administer glucagon, if the home is no longer using glucagon, then how to administer baqsimi.

b. The Diabetic Management-Hypoglycemia Policy: RC- 24 -01-02.

c. Who is responsible for administering the glucagon or baqsimi

d. Medical Directives for Hypoglycemia and transcribing orders to the E-Mar.

e. Provide a list of the registered staff and registered agency staff currently working at the home. Keep a documented record of what education was provided, the date the education was provided, and the staff's signature indicating the education was provided. Provide this documentation upon request of the inspector.

2. The DOC or designate will keep a list of all diabetic residents currently residing in the home. The DOC or designate will check all these residents' Medical Directives to ensure the hypoglycemia orders have been transcribed to the E-Mar. If the diabetic resident does not have a medical directive on the E-Mar indicate the reason why. Keep a documented record of the diabetic's name and the date the E-Mar was

checked that the Medical Directive for hypoglycemia was transcribed and provide the documentation upon request of the inspector.

3. The DOC or designate will develop a process to audit the Hypoglycemia Medical Directives, to ensure they are transcribed to the E-mar. Keep a documented record of the process and provide this documentation upon request of the inspector.

Grounds

The licensee has failed to ensure that every use of a specific medication, every incident of severe hypoglycemia involving a resident, corrective action is taken as necessary.

Rationale and Summary:
A CIR was submitted to the Director indicating a resident 's blood sugar was low. The resident received medication to increase their blood sugar. After two doses of this medication there was no improvement in the resident's condition, Emergency Services were called, and the resident was transferred to hospital.

After the resident's hypoglycemic event the DOC submitted a medication incident report to the pharmacy. The medication incident report indicated the contributing factor to resident's hypoglycemic event was a staff education problem and reported they would provide education to the registered staff regarding the hypoglycemia policy and protocols.

The DOC completed a Post Event Follow up form to investigate the residents' low blood sugar. The form indicated to follow up with each person involved to ensure understanding of their role in the event. The DOC indicated on the form they followed up with a specific RPN and RN. The RN was not mentioned on the form even though they were the RN in charge that night. The form also indicates to identify the corrective action and record recommendations to prevent reoccurrence. The DOC indicated that re-education was being incorporated into nursing practice

meetings and Surge Education. The form did not include if the corrective action was implemented and who was receiving the education.

Review of the residents' clinical records indicated the resident's blood sugar was low and the RPN tried to administer the resident sugar, the resident took two spoons, but then the resident refused to take anything else orally. The RN was made aware of the situation and advised the RPN to continue to try to offer the resident oral glucose. At the end of the RPN's shift they tried to offer the resident oral intake however the resident was not able to ingest anything orally, the resident's blood sugar was rechecked, and their blood sugar remained low. The RPN reported this to the oncoming shift. The RN assessed the resident and administered a medication to increase the residents blood sugar. The residents blood sugar did not improve, and a second dose of the same medication was given. After the second dose of the medication the resident's blood sugar (BS) did not improve and the resident was transferred to hospital.

The home's policy provides direction to registered staff on how to manage residents with low blood sugar.

The home's Medical Directive provides direction to staff on how to implement physician's orders under specific conditions without a direct assessment by the physician.

The RPN agreed residents' blood sugar was not rechecked as outlined in the Diabetic policy. The RPN acknowledged the resident should have been given a medication to increase their blood sugar when they were not able to orally ingest glucose and their blood sugar was low. The RPN reported they had spoken to the RN that the resident's blood sugar was low, and that the resident would not take the oral glucose. The RPN reported they requested the RN give the resident a medication to increase their blood sugar, but the RN indicated to keep offering the resident oral glucose. The RPN reported the RN did not come up to assess the

resident and they did not call the RN back until the end of their shift, the resident's blood sugar was rechecked and had further dropped. The RPN was not aware they could administer a medication to increase the resident blood sugar.

The RN reported they were the RN in charge and agreed the RPN reported to them that the resident had a low blood sugar. The RN reported they advised the RPN to try to give the resident oral glucose to raise their blood sugar and to call them back if ineffective. The RN reported the RPN, called them again prior to the end of their shift to report the resident's blood sugar was lower and the oncoming RN went to assess the resident. The RN working that night with the RPN reported they were not sure if RPN's could give medication to increase a resident blood sugar and agreed they did not assess the resident.

The incoming RN received report about resident's condition and after assessing the resident they administered a medication to increase the residents' blood sugar. After two doses of this medication and no improvement in the residents' blood sugar the resident was sent to hospital. The RN acknowledged the Medical Directive for the resident, was not on the E-mar, but realized diabetic residents should have Medical Directives when a resident has a low blood sugar and checked the residents chart. The RN confirmed they transcribed the medication order from the residents' Medical Directive to the E-Mar. The RN agreed the resident's Medical Directive should have been transcribed to the resident's E-Mar when it was ordered.

The DOC acknowledged the RPN did not follow the home's policy when the resident's blood sugar was low. The DOC further acknowledged that the RN working that night with the RPN should have been part of their investigation notes after the hypoglycemic event and agreed that corrective action had not yet been provided to educate these two staff members that worked the night.

Failing to ensure the Medical Directive for a resident's medication was transcribed to the resident 's E-Mar, put the resident at risk as staff may not be aware the

medication was ordered. Failing to ensure corrective action was taken and education was provided to the registered staff working that night on the homes' policy could have impacted the resident's health. Failing to ensure the Charge Nurse was provided education on their responsibility as a charge nurse and assessing the resident, and following up with the RPN when they reported a change in the resident health put the residents' health at risk. Failing to ensure that all staff are aware of their roles and responsible for giving a resident a medication when their blood sugar is low puts all residents at an increased risk for a delay in treatment during a hypoglycemic event and puts the resident's health at risk.

Sources: CIR, the home's policy, a residents' clinical records, interviews with staff and the DOC.

This order must be complied with by October 7, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor

Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.