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

Hamilton Service Area Office
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date September 14, 2022
Inspection Number 2022_1167_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Maryban Holdings Ltd.

Long-Term Care Home and City
Oakwood Park Lodge, Niagara Falls

Lead Inspector
Kelly Hayes (583)

Inspector Digital Signature
Kelly Hayes Digitally signed by Kelly Hayes
Date: 2022.09.14 10:37:25 -04'00'

Additional Inspector(s)
Karlee Zwierschke (740732)
Nishy Francis (740873)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 24, 25, 26, 29, 2022

The following intake(s) were inspected:

- Log # 003202-21 (CI: 2661-000004-21) related to abuse/neglect.
- Log # 014107-21 (CI: 2661-000014-21) related to hypoglycemia.
- Log #006864-21 (Follow-up) related to IPAC.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 229 (4)	2021_820130_0003	001	Kelly Hayes (583)

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

- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours

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INSPECTION RESULTS

WRITTEN NOTIFICATION [DIRECTIVES BY MINISTER]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 *s.* 174.1(3)

The licensee has failed to carry out the Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, dated April 15, 2020.

As per the Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, section 5 titled "Documentation, Review and Analysis", subsection (2)(b) required the licensee to take corrective action for every incident of severe hypoglycemia or unresponsive hypoglycemia involving a resident.

Specifically, as per the Directive the licensee did not ensure corrective action was taken when a resident required interventions for severe hypoglycemia.

The home's policy titled Care of Resident with Diabetes policy, last revised February 28, 2020, outlined corrective action that registered staff were to follow for residents with severe hypoglycemia.

On an identified date, the resident experienced multiple hypoglycemic events. In the event the resident's blood sugar was low; staff were to follow the homes policy. The corrective action to be implemented by registered staff was to provide the nonpharmacological intervention and in the event the resident could not tolerate this, they were to be administered an identified drug. The resident's blood sugar was to be retested within 15 minutes. In the event the blood sugar remained less than 2.8 mmol/L, the resident required the above-mentioned interventions and blood sugar was to be re-tested within 15 minutes.

A review of the capillary blood glucose readings on an identified date, indicated the resident experienced multiple occasions of severe hypoglycemia and was subsequently transferred to hospital. The resident's blood sugar required re-testing within 15 minutes as per policy and was not re-tested on multiple occasions when the resident experienced severe hypoglycemia. Interview with the Registered Nurse (RN) and the Assistant Director of Care (ADOC) confirmed that the resident's blood sugar had not been retested within 15 minutes and that the policy had not been complied with.

The RN confirmed they should have administered an identified drug on one occasion as specified in the medical directive and the policy when the resident experienced severe hypoglycemia and they were having difficulty tolerating fluid interventions.

The ADOC confirmed that registered staff should have administered the medication when the resident experienced severe hypoglycemia and they were having difficulty tolerating fluid interventions. RN #103 affirmed they had received training on the Hypoglycemia Algorithm and the Care of Residents with Diabetes Policy and did not implement interventions as per the policy in this incident.

When corrective actions were not taken as per the home's policy related to the care the resident with diabetes, there may have been a risk of harm to the resident's health status and well being.

Sources: Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, dated April 15, 2020; resident's capillary blood glucose values; the licensee's Care of Resident with Diabetes policy and corresponding Hypoglycemic Algorithm (revised February 28, 2020); and interviews with the Assistant Director of Care and nursing staff.

[740873]