Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 24, 2023
Original Report Issue Date: August 15, 2023
Inspection Number: 2023-1298-0003 (A1)
Inspection Type: Critical Incident
Licensee: Chartwell Master Care LP
Long Term Care Home and City: Chartwell Pine Grove Long Term Care Residence,Woodbridge

Amended By	**Inspector who Amended Digital Signature**
Yannis Wong (000707)	

AMENDED INSPECTION SUMMARY

This report has been amended to:

- Update the Report Issue Date
- Clarify audits for hypoglycemia are for all episodes below 4 millimoles per litre (mmol/L)
- Clarify the training component must be completed by the compliance due date

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Lead Inspector Yannis Wong (000707)	**Additional Inspector(s)** Rajwinder Sehgal (741673)
Amended By Yannis Wong (000707)	**Inspector who Amended Digital Signature**

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- Update the Report Issue Date
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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1-4, 2023

The following intake(s) were inspected in the Critical Incident (CI) inspection:
Intake: #00015150 - [CI #2808-000018-22] - Potential injury with unknown cause
Intake: #00015317 - [CI #2808-000020-22] - Episode of hypoglycemia with glucagon administered
Intake: #00088010 - [CI #2808-000019-23] - Alleged physical abuse from staff towards a resident

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

AMENDED 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 (7)

The licensee has failed to ensure that care set out in the care plan was provided to a resident as specified in the plan.

Rationale and Summary
A resident's care plan indicated that the resident required two staff assistance for an Activity of Daily Living (ADL) due to their responsive behaviours.

During an observation, a Personal Support Worker (PSW) was alone when providing assistance to the resident for the task. The PSW was aware of the resident's care plan and confirmed a second staff was not present when they assisted the resident with the task.

Director of Care (DOC) confirmed that the resident required two staff assistance for the task at all times and acknowledged that the resident's care plan was not followed as required.

There was risk of harm to the resident when the care plan was not followed.

Sources: Observation, care plan, interviews with PSW and DOC.

[741673]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting two residents.

Rationale and Summary
i) A resident required two staff assistance for transferring and bed mobility due to their responsive behaviours.

In two separate incidents, a review of the camera footage provided by the home revealed that two PSWs positioned their hand on a resident's neck when assisting them during a transfer.

The home's internal investigation notes indicated that both PSWs transferred the resident to the bed even though the resident was resistive during the transfer.

One of the PSWs indicated that they should have placed their hand on the resident's shoulder to support the resident. They acknowledged the resident's transfer was unsafe.

DOC acknowledged that both PSWs handled the resident in an unsafe manner and had not used safe transferring techniques when assisting the resident.

There was risk of harm to the resident when the safe transferring technique was not followed.

Sources: CIS report, camera footage, clinical records, home's investigation notes, interviews with PSW, DOC and other staff.

[741673]

ii) A resident required the use of a transferring device with two-person physical assist for all transfers.

In an interview with a PSW, they admitted using the incorrect transferring device to transfer the resident. The PSW stated they did not check the resident's care plan to confirm if the device was assigned for the resident. Later that day, the resident experienced pain and an injury was noted. The resident was transferred to the hospital for further assessment related to pain and injury.

A review of the home's internal investigation notes indicated that the PSW did not follow the resident's plan of care and transferred the resident in an unsafe manner by using the wrong transferring device.

DOC acknowledged that the PSW did not use a safe transferring technique when assisting the resident.

There was actual harm to the resident when the safe transferring technique was not followed.

Sources: CIS report, clinical records, home's investigation notes, interviews with PSW, DOC, and other staff.

[741673]

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the home's "Diabetic Management" policy, dated June 2023.

Ontario Regulation 246/22, s. 123 (2) required written policies developed for the medication management system to ensure safe administration of drugs used in the home.

In accordance with O. Reg. 246/22, s. 11 (1)(b), the licensee is required to ensure that the written policies were complied with.

Rationale and Summary:
The home's policy titled "Diabetic Management" directed registered staff to obtain and record the Capillary Blood Glucose (CBG) prior to every administration of insulin.

A resident has received insulin since admission. There were no scheduled orders of CBG during a specified period. CBG checks were documented on two dates related to hypoglycemia. There were no other CBG checks documented in the plan of care for this period of time. A Registered Practical Nurse (RPN) recalled the resident received insulin daily but there was no order for daily CBG checks. The DOC confirmed there was no ongoing order for CBG between the specified dates.

An RPN and DOC stated the resident has refused CBG in the past. However, the DOC acknowledged there was no documentation of refusal in the plan of care prior to a specified date. The resident's attending physician and the DOC confirmed the home's policy requires residents receiving insulin to have daily CBG completed and that the CBG checks should be in place for the resident.

The licensee's failure to ensure the resident received CBG prior to every administration of insulin put the resident at risk of hypoglycemia and complications.

Sources: The home's Diabetic Management policy (LTC-CA-BC-ON-200-03-02, last revised June 2023); clinical records; medication administration records; interviews with RPNs, DOC, and physician

[000707]

WRITTEN NOTIFICATION: Residents' drug regimes

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)

The licensee has failed to ensure that staff completed monitoring and documentation after a resident received glucagon for severe hypoglycemia.

Rationale and Summary
A resident received glucagon on multiple dates. RPN #101 and RPN #102 completed one follow up CBG check after glucagon was given to the resident on each of the dates.

The home's policy titled "Hypoglycemia and Glucagon" states that following an episode of hypoglycemia, once CBG is above 4 millimoles per litre (mmol/L), staff are to continue to monitor CBG every hour for the next 4 hours.

RPN #101 acknowledged they only completed one CBG check post-glucagon administration. The DOC confirmed that only one follow up CBG check was completed on the specified dates and the home's policy for monitoring CBG after hypoglycemia was not followed.

Sources: Interviews with RPN #101, RPN #102, DOC, clinical records; and the home's "Hypoglycemia and Glucagon" policy (LTC-CA-BC-ON-200-03-04, last revised June 2023)

[000707]

COMPLIANCE ORDER CO #001 Directives by Minister

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Train all registered nursing staff on the specified home area (including RPN #101, RPN #102, and agency staff) on the home's policies and procedures related to hypoglycemia and glucagon, and on the legislative requirements in O. Reg. 246/22 s. 147 by the compliance due date.
2. Maintain a record of training; including who attended the training, time and date, who conducted the training, topics covered in the training.
3. Audit all episodes of hypoglycemia (below 4 mmol/L) following the date of service of this order through the compliance due date to ensure the appropriate steps are followed based on the resident's plan of care, the home's policies related to hypoglycemia and glucagon, and legislative requirements in O. Reg. 246/22 s. 147.
4. Maintain a record of audits; including who conducted the audit, time and date, who was notified, and actions taken in response to the audit.

Grounds
The licensee has failed to ensure the long-term care home complied with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, updated April 11, 2022.

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, updated April 11, 2022, the licensee was required to ensure that every use of glucagon in a long-term care home was:
a) reported to the Director of Care (DOC), the resident's attending physician and Medical Director, and pharmacy service provider;
b) reviewed and analyzed, corrective action was taken, and a written record was kept; and
c) evaluated by the interdisciplinary team at least quarterly to identify utilization trends and patterns and to identify any changes necessary to improve the use of glucagon in the home.

Rationale and Summary
A resident had an episode of hypoglycemia with glucagon use. The DOC completed a medication incident report and the corrective action plan included frequent monitoring of blood glucose. However, the action plan was not carried out. There was no physician order for CBG checks. There were no CBG checks documented until a subsequent episode of hypoglycemia, where glucagon was also used. The DOC confirmed there was no documentation of CBG checks or documentation of resident refusal

between specified dates.

The resident had further episodes of hypoglycemia with glucagon use. An RPN documented the administration of glucagon. The resident’s attending physician, who was also the home’s Medical Director, and DOC were not notified about the glucagon usage for the dates. As a result, there were no follow up actions completed including review and analysis of the glucagon use and corrective actions were not taken. The incidents were not reviewed by the home’s interdisciplinary team in the quarterly review.

There was risk to the resident as the identified corrective action of frequent CBG monitoring was not implemented and required follow up was not completed, which may have contributed to the resident having subsequent incidents of severe hypoglycemia.

Sources: CI, Minister’s Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia updated April 11, 2022; interviews with RPN, DOC, physician/Medical Director; clinical records; physician communication book; meeting report; and medication incident report

[000707]

This order must be complied with by September 6, 2023

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.