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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: November 6, 2023	
Inspection Number: 2023-1157-0006	
Inspection Type: Complaint	
Licensee: Tendercare Nursing Homes Limited	
Long Term Care Home and City: Tendercare Living Centre, Scarborough	
Lead Inspector Suzanna McCarthy (000745)	**Inspector Digital Signature** Suzanna McCarthy Digitally signed by Suzanna McCarthy Date: 2023.12.05 14:08:58 -05'00'
Additional Inspector(s) Nicole Lemieux (721709) Ana Best (741722)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12 to 15, 18, 20 to 22, 25 and 26, 2023.

The following intake(s) were inspected:

- Intake: #00086623 - Complaint related to medication management.

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

Medication Management

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 MANDATORY REVIEW AND ANAYLISIS OF HYPOGLYCEMIC EVENTS

NC #001 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. To immediately establish an interdisciplinary team which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider.
2. Establish a schedule for a minimum of one meeting per quarter and conduct an evaluation and review of every incident of severe hypoglycemia or unresponsive hypoglycemia and every incident in which glucagon was administered.
3. Maintain written records of all meetings as well as records of the analysis of any trends and patterns identified, and any changes implemented in accordance with best practices or prevailing practices.
4. Keep a documented record of all the above and provide to Inspector upon request.

Grounds

The licensee has failed to ensure that where the Act required the licensee of a Long-Term Care Home (LTCH) to carry out every operational Minister's Directive that applies to the LTCH, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive, Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia for LTCHs in Ontario, dated April 11, 2022, the licensee was required to conduct a quarterly and annual review of the use and administration of glucagon following a severe hypoglycemic event for resident #005.

Rationale and Summary

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, effective April 15, 2020, the licensee of a LTCH shall ensure that every use of glucagon involving a resident is reviewed and analyzed, corrective action is taken as necessary, and a written record is kept. The licensee shall ensure that an interdisciplinary team which must include the Medical Director, the Administrator, the Director of Care (DOC) and the pharmacy service provider meets at least quarterly to evaluate every written analysis and corrective action to identify trends and patterns and changes necessary to improve the use of a glucagon in accordance with evidence-based practices and, if there are none in accordance with prevailing practices. The licensee shall ensure that the changes are identified in the quarterly evaluation and implemented. The licensee shall ensure a written record is kept of the results of the quarterly evaluation and any changes that were implemented.

A complaint was submitted to the Director related to the unexpected death of resident #005. Clinical records for resident #005 indicated that Registered Practical Nurse (RPN) #129 observed the resident to be eating breakfast at 0902 hours (hrs). Upon returning to the resident's room at 1055 hrs, the RPN reported the resident was sleeping while experiencing a hypoglycemic event with a blood glucose level of 1.9millimoles per Litre (mmol/L). RPN #129 documented that they administered juice, then four dextrose tabs, and then administered glucagon. The RPN reported that three minutes later they rechecked the resident, whose blood glucose measured at 1.3 mmol/L with no pulse, no noted heartbeat and a weak carotid pulse with no radial pulse. The resident's medical directive as well as the LTCH's policy Diabetes Management-Hypoglycemia required that a resident with a blood glucose level of 2.4 mmol/L or less who is not responsive, unable to swallow or unconscious, was to have glucagon administered intramuscularly.

Failing to review and analyze hypoglycemic events with the established interdisciplinary team on an annual and quarterly basis as required in the Minister's Directive put resident #005 at increased risk of negative outcomes as a result of a hypoglycemic event as corrective actions and/or improvements were not discussed and explored.

Sources:

Clinical records, interview with DOC. [000745]

This order must be complied with by

January 3, 2024

COMPLIANCE ORDER CO #002 MEDICATION MANAGEMENT SYSTEM

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

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

1. A designate from the pharmacy service provider shall provide training to all registered staff on hypoglycemic event management. At a minimum the training should include the LTCH's policy Diabetes Management-Hypolgycemia, how to respond to hypoglycemic events, when and how to make referrals to the physician/nurse practitioner about hypoglycemic events.
2. Maintain a documented record of the education provided, the list of attendees, the education completion date, and the contents of the education and training materials.

3. Administer a supervised test to all registered staff post training. Ensure all staff are completing testing independently and without aid. Ensure that any staff receiving a final grade of less than 85% on the test is provided with retraining and is retested on the materials. Maintain a documented record of the test materials, the administration record, and the final grades for each participant as well as the date the test was administered.

Grounds

The licensee has failed to ensure that medication management system polices and protocols as it related to hypoglycemic event management were implemented.

Rationale and Summary

A complaint was submitted to the Director related to the unexpected death of resident #005. Clinical records for resident #005 indicated that RPN #129 observed the resident to be eating breakfast at 0902 hrs. Upon returning to the resident's room at 1055 hrs, the RPN reported the resident was sleeping while experiencing a hypoglycemic event with a blood glucose level of 1.9 mmol/L. RPN #129 documented that they administered juice, then four dextrose tabs, and then administered glucagon. The RPN reported that three minutes later they rechecked the resident, whose blood glucose measured at 1.3 mmol/L with no pulse, no noted heartbeat and a weak carotid pulse with no radial pulse. The resident's medical directive required that if a resident had a blood glucose level of 2.4 mmol/L or less and is not responsive, unable to swallow or unconscious, glucagon was to be administered.

Clinical records for resident #005 showed that the resident experienced hypoglycemic events as follows: February 14, 2023 a reading of 2.8 mmol/L; February 17, 2023 a reading of 3.1 mmol/L; February 19, 2023 a reading of 3.6 mmol/L; and on February 21, 2021 a reading of 1.9 mmol/L. Additional records show that on February 14, 2023 physician #130 ordered insulin to be held in response to the hypoglycemic event. It was also recorded in a nutrition note by staff #132 that the resident had poor intake, eating only 25-50 percent (%) of meals.

The LTCH's policy titled, Diabetes Management-Hypoglycemia defined a hypoglycemic event as a blood glucose of 3.9mmol/L or less. As per the policy, the licensee is to reduce the diabetes management interventions if the resident experiences a pattern of hypoglycemia events (greater than once per month) and notify a physician or nurse practitioner. In the residents' clinical files, there was no notification to the physician or nurse practitioner for the repeated hypoglycemic events after February 14, 2023.

Failure by the licensee to follow implemented policies with regards to hypoglycemia put resident #005 at high risk of poor outcomes as a result of repeated hypoglycemic events.

Sources:

Resident's health record, interviews with staff, letter of complaint from Coroner. [000745]

This order must be complied with by

November 30, 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.