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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 19, 2021	2021_792659_0002 (A1)	020653-20	Critical Incident System

Licensee/Titulaire de permis

MacGowan Nursing Homes Ltd.
719 Josephine Street P.O. Box 1060 Wingham ON N0G 2W0

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

Braemar Retirement Centre
719 Josephine Street North, R.R. #1 P.O. Box 1060 Wingham ON N0G 2W0

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

Amended by JANETM EVANS (659) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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

This licensee inspection report has been revised to reflect a correction of the medication that was administered to the resident on October 12, 2020. The Critical Incident inspection, #2021_792659_0002 was completed on January 20-21, 2021.
A copy of the revised report is attached.

Issued on this 19th day of February, 2021 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by JANETM EVANS (659) - (A1)

Amended 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 20-21, 2021.

The following intake was included in this inspection: Log #020653-20\Critical Incident (CI) #2788-000011-20, related to administration of glucagon with hospital transfer.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), a Personal Support Worker (PSW), Housekeeping staff and a resident.

A brief tour of the home was conducted and observations made related to medication administration, medication storage and infection prevention and control (IPAC). A review of relevant clinical documentation was completed which included but was not limited to policies and procedures, plan of care, electronic medication administration records, medication incidents and training records.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication

During the course of the original 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure the Management of Hypoglycemia policies and procedures included in the required Medication Management System were complied with, for resident #001.

O. Reg. s. 114 (1) requires an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 79/10, s. 114 (2) requires that the written policies and protocols be developed to ensure the accurate administration of all drugs used in the home.

Specifically, staff did not comply with the home's policy and procedure for managing and treating hypoglycemia. The procedure documents an algorithm for staff to follow when a resident has a blood glucose of less than 4.0 mmol/Litre (L), or greater than 4 mmol/L and the resident shows signs of hypoglycemia.

Resident #001 had an incident of unconscious hypoglycemia. Agency staff did not follow the home's algorithm for management of hypoglycemia. Instead they attempted to administer food to the resident without effect. An ambulance was called and upon arrival, attendants administered Dextrose 10% with good effect and transferred the resident to hospital for assessment. The Agency staff member said they had not been trained on the procedure and were not familiar with where glucagon was kept in the home.

Three months later, resident #001 had a severe hypoglycemic incident. Staff did not follow the home's algorithm for treatment of hypoglycemia nor did they immediately call a physician for further orders after the administration of glucagon.

The home's policy and procedures for treatment of hypoglycemia and unconscious hypoglycemia were not followed. Failure to follow the home's documented procedure for management of severe hypoglycemia may put the resident at risk of an incident of unconscious hypoglycemia or other potential health complications.

Sources :
Resident #001's progress notes,"Management of Hypoglycemia" procedures, dated November 2020, Medication Incident Report and Analysis form dated October 12, 2020 and January 5, 2021, CI: 2788-000011-20, and interview with an RN and the DOC. [s. 8. (1) (b)]

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 registered staff are trained in and follow the licensee's policy Management of Hypoglycemia, 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 LTCHA, 2007, S.O. 2007, c.8, s. 174.1 Directives by Minister. Specifically, the Licensee failed to comply with the following: s. 174.1(3) Every licensee of a long-term care home shall carry out every operational policy and 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. This included that every incident of unresponsive hypoglycemia involving a resident was to be documented along with a record of the immediate actions taken to assess and maintain the resident's health.

Surge training related to the Minister's Directive had been initiated October 2020, with 8/82 staff or 9.8 percent of staff completing the education. Agency staff said they had not received the training at the time of an unconscious hypoglycemic incident, and had not followed the home's procedure for treatment of hypoglycemia, as they were not familiar with it.

Training on the Minister's Directive was not 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 :
CI #2788-000011-20, Surge training related to Public Inquiry into the safety and security of residents in Long Term Care (LTC) homes; Minister's Directive, Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, dated February 13, 2020, and interviews with an RN and the 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, to be implemented voluntarily.

Issued on this 19th day of February, 2021 (A1)

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

Original report signed by the inspector.