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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 27, 2021	2020_610633_0028	003457-20, 006673-20, 015742-20	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor Toronto ON M4W 3L4

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

Castleview Wychwood Towers
351 Christie Street Toronto ON M6G 3C3

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

SHERRI COOK (633), JANETM EVANS (659)

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): December 8-11, 14-17, 21-23, 2020.

The following Critical Incident System (CI) intakes were completed during this inspection:

Log #015742-20- related to Hypoglycemia.
Log #006673-20- related to responsive behaviours.
Log #003457-20- related to falls prevention.

Complaint inspection 2020_610633_0029 was completed concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Administrator, a Nurse Practitioner (NP), Nurse Managers (NMs), Registered Nurses (RNs), the Infection Prevention and Control Lead (IPAC Lead), an Occupational Therapist (OT), a Social Worker (SW), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Physiotherapist Aide (PTA), a Support Assistant (SA), a Personal Care Assistant (PCA) and residents.

The inspector(s) observed resident care/staff interactions, medication administration and IPAC practices. The plan of care for the identified residents and the home's related documentation and policies were also reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Responsive Behaviours

During the course of this 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 :

The licensee has failed to ensure that the home's policy and procedure regarding the management of Hypoglycemia, as part of the home's required Medication Management Program, was complied with for a resident.

O. Reg. 79/10 s. 114(2) required written policies and protocols that ensured the accurate administration of all drugs used in the home.

Specifically, staff did not comply with the home's Hypoglycemia policy and procedure.

The resident had an episode of Hypoglycemia. Staff did not comply with the home's Hypoglycemia policy and procedure in response. The resident was at risk for worsening symptoms of Hypoglycemia. Multiple staff had varying responses on how to respond to Hypoglycemia despite the home's policy, procedure and staff training.

Sources: The resident progress notes, medication administration record (MAR), the home's policy Management of Hypoglycemia (June 2020), interviews with RPNs, NM, NP, the DOC and others.

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 the home's policy and procedure regarding the management of hypoglycemia is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that Glucagon for Hypoglycemia was administered to a resident in accordance with the prescriber's directions for use.

The resident had a severe episode of Hypoglycemia. Their as needed (PRN) dose of Glucagon was not administered as prescribed. The resident was at risk for worsening symptoms of Hypoglycemia and they required further intervention and treatment as a result of this incident.

Sources: The resident progress notes, medication administration record (MAR), interviews with RPNs and others.

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 Glucagon is administered in accordance with the prescriber's directions for use, to be implemented voluntarily.

Issued on this 1st day of February, 2021

[redacted]

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

Original report signed by the inspector.