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
Feb 21, 2020	2020_830752_0002	023259-19	Complaint

Licensee/Titulaire de permis

2063415 Ontario Limited as General Partner of 2063415 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Boulevard BRAMPTON ON L6R 3B5

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

LUCIA KWOK (752)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 16, 17, 20- 24, 27, and 28, 2020.

The following intake was completed in this complaint inspection:
Log #023259-19 related to concerns of plan of care, maintenance services, personal support services.

During the course of the inspection, the inspector(s) spoke with residents, Director of Care (DOC), Assistant Director of Care (ADOC), Executive Director (ED), Environmental Services Manager (ESM), Environmental Services Staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), and Personal Support Workers (PSW).
The inspector conducted a tour of the home and observed the provision of care, and resident and staff interactions. The inspector reviewed pertinent clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services

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 :

1. The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 26 (1), and in reference to O. Reg. 79/10, s. 26 (3) 19, the licensee was required to ensure the plan of care included an interdisciplinary assessment of the resident's safety risk.

Specifically, the staff did not comply with the licensee's policy titled, "Diabetes Management – Hypoglycemia", Policy #VIII-C-10.30, last revised May 2019, to reduce the risk and number of incidents of hypoglycemia for residents with Type 1 or Type 2 Diabetes.

A complaint submitted to the Ministry of Long-Term Care (MLTC) reported concerns of blood glucose monitoring.

The home's policy titled, "Diabetes Management- Hypoglycemia", Policy #VIII-C-10.30, last revised May 2019, directed registered staff to promptly treat residents who exhibited known signs of hypoglycemia, whose blood glucose readings were below 4mmol/L, and/or as per physician/nurse practitioner orders. The policy directed registered staff to notify the physician or nurse practitioner of any hypoglycemic reaction, send a referral to the Registered Dietitian (RD), and provide the resident and/or their Substitute Decision Maker (SDM) with a status update. All assessments, interventions and outcomes were to be documented in the clinical records.

A) Resident #003's clinical records documented blood glucose monitoring related to an

identified medical diagnosis.

Review of the resident's clinical records showed hypoglycemic episodes on specified dates.

There was no documentation to indicate that treatment was provided, that the physician, resident and/or SDM were notified, and there was no referral made to the RD on the specified dates. RD #115 stated they did not receive a referral following the hypoglycemic episodes.

B) Resident #006 's clinical records documented blood glucose monitoring related to an identified medical diagnosis.

Review of the resident's clinical records showed hypoglycemic episodes on specified dates.

The resident’s clinical record did not show a referral was made to the RD on specified dates.

There was no documentation to indicate that treatment was provided, that the physician, resident and/or SDM were notified, and there was no referral made to the RD on the specified dates.

RD #115 stated they only became aware of the resident's hypoglycemic episodes days after they occurred when they were completing their routine nutrition assessment.

Director of Care (DOC) #101 stated that as per the home’s policy, registered staff should have promptly treated the resident experiencing the abnormal blood glucose, notified the physician and the resident and/or their SDM. They said that registered staff are expected to send referrals to RD for each hypoglycemic episode.

The licensee failed to ensure that the home’s policy for the safe and timely management of hypoglycemia was compiled with for residents #003 and #006. [s. 8. (1) (a),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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to implement the procedure to ensure suction machines were kept in good repair and maintained and cleaned at a level that met manufacturer specifications.

A complaint submitted to the MLTC reported concerns that a suction machine was not functioning during an emergency.

The manufacturer's instruction guide for the suction machine, Devilbiss Vacu-Aide Compact Suction Unit, Model 7310 Series, stated that a red light would illuminate on the low battery symbol when the battery was discharged. It further stated that if the unit did not receive external power or the battery has not been charged, the low battery indicator light would remain illuminated and the performance of the unit would drop rapidly. The guide stated that if the low battery symbol was illuminated, to switch to another power source to avoid an interrupted suction procedure. The guide instructed that whenever there was a patient change, the unit should be cleaned and disinfected and all accessory components that were not suitable for reuse such as, collection container, filter, tubing,

and carrying case, should be disposed of.

Registered Practical Nurse (RPN) #109 stated that the red battery signal meant the suction machine was at low battery. They stated that once the suction machine had been used, registered staff were to clean and disinfect the machine as well as dispose of used accessory components and replace with new sterile supplies.

Observation was completed on an identified date in an identified home area. The suction machine labeled, 2A-Garden, was sitting on top of the fridge in the dining room. It was not plugged into a power source and the battery signal was red. RPN #114 demonstrated turning the machine on by pressing the green button, however, the machine turned on for 1 second and then immediately turned off. The RPN attempted to turn on the machine three times without success.

On an identified date, Long-Term Care Homes (LTCH) inspector#752 and RPN #113 observed an opened catheter package in the bag of the suction machine labeled RHA-Lake and an opened connecting tube package in the bag of the suction machine labeled RHA-Cottage.

On an identified date, LTCH inspector #752, RPNs #116 and #117 observed one opened tubing package in the suction machine bags in two other resident home areas, respectively. The RPNs discarded the opened packages into the trash and stated they would replace them with sterile, unopened packages.

DOC #101 acknowledged that the home had not implemented its procedure to ensure that suction machines were kept in good state of repair, maintained and cleaned. The DOC stated that all supplies for the suction machines should be in sterile, unopened packages. The DOC stated that the opened packages of tubing had been replaced with sterile, unopened packages.

The licensee failed to ensure that the suction machines, were maintained at a level that met the manufacturer specifications, at a minimum. [s. 90. (2) (a)]

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 procedures are developed and implemented to ensure that, electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum, to be implemented voluntarily.

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.