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: June 29, 2023

Inspection Number: 2023-1592-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: The Corporation of the City of Kawartha Lakes

Long Term Care Home and City: Victoria Manor Home for the Aged, Lindsay

Lead Inspector	**Inspector Digital Signature**
Lynda Brown (111)	Lynda Brown Digitally signed by Lynda Brown Date: 2023.07.19 10:28:26 -04'00'

Additional Inspector(s)
Marian Keith (741757)
Sami Jarour (570)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15 - 18, 23 - 26, 29 -31, June 1- 2, 5-6 and 8, 2023.

The following intake(s) were inspected:

- Intake: #00016415 - First follow-up to Compliance Order #001 related to duty to protect.
- Intake: #00016416 - First follow-up to Compliance Order #002 related to transferring and positioning techniques.
- Intake: #00014929 - complaint related to responsive behaviours, falls and injury of unknown cause
- Intake: #00002088 - [CI] related to alleged neglect and improper care.
- Intake: #00006250 - [CI], Intake: #00014064- [CI], Intake: #00017557- [CI], Intake: #00084828- [CI], Intake: #00086238- [CI] and Intake: #00086461-[CI] related to alleged staff to resident abuse.
- Intake: #00014174 - [CI], Intake: #00018498 - [CI], and Intake: #00084890 - [CI] related to alleged resident to resident abuse.
- Intake: #00014202 - [CI] and Intake: #00017042 - [CI] related to responsive behaviours.
- Intake: #00019802 - [CI] related to medication incidents/adverse drug reactions.

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The following intakes were reviewed during this inspection:

- Intake: #00087428 - [CI] and Intake #00022358 [CI] related to medication incidents/adverse drug reactions.
- Intake: #00087463 - [CI] related to a disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1592-0001 related to FLTCA, 2021, s. 24 (1) inspected by Sami Jarour (570)

Order #002 from Inspection #2022-1592-0001 related to O. Reg. 246/22, s. 40 inspected by Lynda Brown (111)

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
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to ensure the Director was immediately notified of an alleged staff to resident abuse incident involving a resident.

Rationale and Summary

A critical incident (CI) was reported to the Director for an alleged staff to resident abuse incident. A PSW and an RCA witnessed another PSW being abusive towards a resident. The PSW immediately reported the incident to an RPN.

The home's investigation revealed the RPN did not immediately report. The Administer confirmed the Director was not informed of the witnessed incident of staff to resident abuse until the next day, when they became aware of the incident.

Failing to immediately notify the Director of a witnessed incident of staff to resident abuse led to a delay in the investigation.

Sources: CI, a resident's health records, home's investigation notes, and interview with the Administrator. [111]

WRITTEN NOTIFICATION: Notification re incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 97 (1) (b)

The licensee failed to ensure the SDM of a resident was notified within 12 hours of upon the licensee becoming aware an alleged staff to resident verbal abuse incident.

Rationale and Summary

A CI was submitted to the Director for an alleged staff to resident abuse incident. The abuse was witnessed by a PSW and immediately reported to an RPN. The home's investigation confirmed the RPN was made aware of the allegation and did not report the allegation to the SDM. The SDM was notified the following day when the management was made aware of the allegation. The Administrator confirmed the SDM was notified the day after the occurrence when they became aware of the incident and should have been notified by the RPN.

Failing to notify the SDM of a resident for a witnessed incident of staff to resident abuse leads to mistrust by families.

Sources: CI, a resident's health records, home's investigation notes, and interview with the Administrator. [111]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007, s. 3(1)1 and s. 3 (1)1 under the FLTCA, 2021.

1.The licensee failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality, was fully respected and promoted.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 3(1)1 of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 3(1)1 under the FLTCA.

Rationale and Summary

A CI was reported to the Director for an alleged staff to resident abuse incident. A PSW and an RCA witnessed another PSW being abusive to a resident. Review of the homes internal investigation revealed that the PSW involved in the allegation confirmed they had been abusive. The Administrator confirmed the allegation was substantiated.

Failing to treat a resident with courtesy and respect leads to distrust of staff and increases responsive behaviours.

Sources: CI, a resident's progress notes, home's investigation notes and interview with the Administrator. [111]

2.The licensee has failed to ensure that another resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality, was fully respected and promoted.

Rationale and summary

A CI was submitted to the Director for a witnessed staff to resident abuse incident. A PSW reported to an RPN that a resident sustained an injury during care. The CI indicated the resident was demonstrating a responsive behaviour and repeatedly identified another PSW as involved in the abuse.

A PSW indicated they were assisting another PSW during care for the resident and witnessed the other PSW become abusive when the resident began demonstrating responsive behaviours. The resident

sustained an injury as a result. The resident was upset as a result of the incident.

The PSW involved in the allegation confirmed they had been inappropriate and had apologized. The PSW denied awareness of what had caused the injury to the resident but had reported the injury to the RPN. An ADOC indicated the allegation of abuse towards the resident was substantiated.

Failure to treat a resident with respect and dignity, resulted in not following the resident's bill of rights in the Long-Term Care (LTC) home causing harm and emotional distress to a resident.

Sources: CI, health records for a resident, and interviews with PSWs and an ADOC. [570]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's written plan of care was revised when their care needs changed.

Rationale and Summary

A CI report was submitted to the Director for a medication incident that occurred. A resident was found unresponsive due to an alteration in condition, was given medication and then transferred to the hospital. The resident later returned from the hospital and reassessed for additional interventions to be put in place.

Review of the resident's written care plan did not identify the new intervention. The resident confirmed they were receiving the intervention. An RPN confirmed the resident was receiving the intervention.

By not updating the resident's written plan of care, the resident was at risk of not receiving their required interventions to manage their medical diagnosis.

Sources: CI, a resident's clinical records, interviews with the resident and an RPN. [741757]

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on the preferences of the resident.

Rationale and Summary

A complaint was received by the Director regarding a resident's falls. The substitute decision-maker (SDM) of the resident indicated they were concerned about the resident's ongoing falls; they had requested a falls prevention intervention and that was not implemented. They indicated a different intervention had been implemented, was not able to be used and was later removed.

Observations by the Inspector indicated the falls prevention intervention requested by the SDM was not in place.

Review of the progress notes for the resident indicated the resident sustained a number of falls since admission. One of the falls resulted in an injury to the resident and the SDM indicated was due to the falls prevention intervention that they had requested, not being implemented. The progress notes revealed that the resident's SDMs had requested the use of a specific falls prevention intervention on admission and following each of the fall incidents. A number of months later, a different falls prevention intervention was implemented, but not able to be used and then later removed.

The physiotherapist indicated the resident was at risk for injury with the use of the specific falls prevention intervention unless the resident was closely monitored. They indicated awareness of the family's request for the specific falls prevention intervention. They indicated that the resident was assessed for a different type of falls prevention intervention as there were not available.

The Maintenance Coordinator indicated they installed a different falls prevention intervention for the resident and removed it a number of days later as directed by an ADOC. They confirmed the falls prevention intervention was not able to be used after it had been installed. The Maintenance Coordinator indicated they were notified a number of months later to obtain the specific falls prevention intervention as requested by the SDM.

An ADOC indicated the resident sustained a number of falls since admission and the requested falls prevention intervention from the SDMs was contraindicated for the resident and concerns of potential injuries. They confirmed the SDM had provided verbal consent for the specific falls prevention intervention, and a different type had been implemented but not able to be used and then later removed as the SDM had not provided written consent. The ADOC acknowledged the falls prevention intervention had not been implemented when requested by the SDMs.

Failing to ensure that the care set out in the plan of care for the resident was based on the preferences of the resident, could result in the resident's needs not being met.

Sources: a resident's health records, observations, interviews with resident's SDM, physiotherapist, Maintenance Coordinator and an ADOC. [570]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 20 (1) and s. 25(1) under the FLTCA, 2021.

1.The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with for a resident.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 20(1) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 25(1) under the FLTCA.

Rationale and Summary

A CI was submitted to the Director for an alleged staff to resident abuse incident. A PSW and a RCA witnessed another PSW being abusive towards a resident and the PSW immediately reported the incident to an RPN. The home's policy "Prevention of Abuse & Neglect of a Resident" indicated the nurse was to check the resident's condition to assess their safety/emotional and physical wellbeing and document on the resident's health record. There was no documented evidence the resident's condition and safety was assessed at that time.

The RPN no longer worked at the home. The ADOC confirmed the RPN failed to assess and document their assessment of the resident.
Failing to follow the home's prevention of abuse and neglect policy resulted in a delay in assessment of the resident and the required notifications of the abuse for the resident.

Sources: CI, a resident's health record, home's investigation notes, Prevention of Abuse & Neglect of a Resident policy, and interview with an ADOC. [111]

2.The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of

residents, was complied with for another resident.

Rationale and Summary

A CI was submitted to the Director for an alleged staff to resident abuse incident. A PSW witnessed a resident respond to another PSW that alleged abuse by the staff member. The PSW who witnessed the incident did not report the allegation to an RN until the following day, when they witnessed additional incidents of alleged abuse and/or neglect by the same PSW towards five other residents. The PSW was required to immediately inform their charge nurse of any alleged, suspected or witnessed incidents of abuse and/or neglect of a resident by a staff. An ADOC indicated the PSW did not report the allegation until the following day, after they witnessed additional incidents involving the same staff member and that was when they reported the allegations to the Director.

Failing to comply with the home's written policy to promote zero tolerance of abuse and neglect of residents, resulted in a delay in the home investigation into alleged staff to resident abuse and the staff member being allowed to continue to work in the home.

Sources: CI, Prevention of Abuse & Neglect of a Resident policy, home's investigation notes and interview with an ADOC. [111]

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that they immediately forwarded to the Director any written complaint that it received concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

Rationale and Summary

A CI was submitted to the Director for a written complaint/response concerning the care of a resident. The CI indicated that the LTCH received a written complaint concerning the care of a resident and was not immediately forwarded to the Director until a number of days later.

An ADOC indicated the incident was immediately investigated, and an acknowledgement letter and

outcome response letter were sent to the complainant. The ADOC acknowledged that the written complaint was not immediately forwarded to the Director.

Failure to immediately forward written complaints to the Director concerning the care of a resident or the operation of a long-term care home, puts residents at increased risk of harm and delays action from the Director.

Sources: CI, and interview with an ADOC. [570]

WRITTEN NOTIFICATION: Reports of investigation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 23 (2) and s. 27 (2) under the FLTCA, 2021.

The licensee failed to ensure that the report to the Director included the results of the investigation and every action taken for an alleged staff to resident emotional abuse involving a resident.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 23 (2) of LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 27 (2) under the FLTCA

Rationale and Summary

A CI was submitted to the Director for an alleged staff to resident abuse incident. The report to the Director was not amended to include the results of the investigation. The home completed the investigation and concluded the allegation as unfounded as there was no negative effect to the resident. The DOC and an ADOC confirmed they both completed the investigation and had not amended the report to the Director with the results of the investigation.

Failing to provide the results of the investigation to the Director resulted in the Director not being aware that additional residents were identified during the home's investigation.

Sources: CI, health record of a resident, home's investigation notes, and interview with the DOC and an ADOC. [111]

2.The licensee failed to ensure that the report to the Director included the results of the investigation

and every action taken for an alleged staff to resident emotional abuse involving resident #023.

Rationale and Summary

A CI was submitted to the Director for an alleged staff to resident abuse incident. The report to the Director was amended and indicated the investigation had been concluded, but no indication of the results. The Administrator and an ADOC both confirmed the allegations were substantiated and the report to the Director did not contain the results.

Failing to provide the results of the investigation to the Director leads to an incomplete investigation.

Sources: CI, a resident's health records, home's investigation notes, and interview with the Administrator and an ADOC. [111]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a witnessed resident to resident abuse incident involving two residents was immediately reported to the Director.

Rationale and Summary

A CI was submitted to the Director for a witnessed resident to resident abuse incident. One of the residents sustained an injury as a result of the incident. The CI was not submitted to the Director until a number of days later. A review of health records for both residents indicated a PSW witnessed the incident and reported the incident to an RN. The RN confirmed they did not immediately report the incident. An ADOC acknowledged that the incident was not immediately reported by the RN and corrective actions were taken as a result.

Failure to immediately report resident abuse puts residents at risk of additional harm.

Sources: CI, health records for two residents and interviews with an RN and an ADOC. [570]

2.The licensee has failed to ensure that a second witnessed resident to resident abuse incident involving was immediately reported to the Director.

Rationale and Summary

A CI was submitted to the Director for a witnessed resident to resident abuse incident. The CI was not submitted to the Director until a number of days after the incident occurred and one day after an injury was discovered to one of the residents. A review of health records for one of the resident's indicated an RPN noted the presence of an injury to the resident. The DOC acknowledged that the incident was not immediately reported when the injury was discovered as the RPN did not report the injury to the RN.

Failure to immediately report incidents of residents' abuse puts residents at risk of additional harm.

Sources: CI, health records for a resident and interview with the DOC. [570]

WRITTEN NOTIFICATION: Maintenance services

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

The licensee has failed to ensure that procedures were developed and implemented to ensure that a resident's alarming device was kept in a good state of repair for falls prevention.

Rationale and Summary

A complaint was received by the Director regarding a resident's falls. Review of the clinical records revealed that the resident had sustained a number of falls since admission. The resident had an unwitnessed fall, sustained an injury as a result and their alarming device was not functioning as it was in disrepair. The resident was identified at risk for falls and the staff were to implement the use of the alarming device.

An RPN confirmed they were present when the resident was found, and the alarming device had not been activated as it was in disrepair. The Falls Lead indicated staff should have ensured that the alarming device was in good working order.

An ADOC indicated the alarming device not working did not serve the purpose of a falls prevention intervention and that staff were to ensure that falls prevention interventions in place as per the plan of care. They indicated if they were not functional, staff should have alerted the registered staff to replace the device to ensure the residents safety.

Failure to have a functioning alarming device in place resulted in staff not being alerted to the resident's

attempted self-transfer and subsequent fall, causing injury to the resident.

Sources: a resident's progress notes and plan of care; interviews with resident's SDM, RPNs and the ADOC. [570]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

The licensee failed to report to Public Health as soon as possible when two residents had symptoms that met criteria for outbreak according to the home's policy.

Rationale and Summary:

A CI was submitted to the Director for an outbreak in the home. Two residents in the same home area were identified to be exhibiting the same two symptoms on the same date. According to the home's policy of 'Confirming an Outbreak' and the policy's attachment of 'Defining an Outbreak' met the criteria of a suspected outbreak. Public Health (PH) was not notified about the home meeting their outbreak criteria until a number of days later and PH declared the home in outbreak.

The previous IPAC Lead confirmed that the cases should have been reported to PH when they met the criteria of a suspected outbreak.

By not notifying Public Health of a suspected outbreak when identified, places the home risk of further transmission of infection and delays prompt intervention by Public Health in managing the outbreak.

Sources: CI, two resident's clinical records, line listing, home's outbreak policy, and interviews with the IPAC Lead and DOC. [741757]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that expired alcohol-based hand rub (ABHR) found in use was able to meet the 70% to 90% alcohol content.

Rationale and Summary

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, section. 10.1 directs the licensee to ensure that the hand hygiene program includes access to hand hygiene agents that have 70-90% ABHR.

During the initial entry of the home, the home was noted to be in an outbreak. During the tour of the home, Inspector #741757 noted expired hand sanitizer in various areas of the home.

The previous IPAC lead was unable to verify that the expired ABHR maintained the percentage of 70-90% alcohol content after the expiry date and confirmed the home's protocol was to remove expired ABHR.

When the licensee was unable to confirm that the expired ABHR maintained a 70-90% alcohol content at the time of the inspection, there was a risk of ineffective hand hygiene and risk for transmission of infectious agents.

Sources: Observations and interview with an ADOC. [741757]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (5)

The licensee has failed to ensure that their Infection Prevention and Control (IPAC) lead had the required education and experience upon commencement of their position.

Rationale and Summary

An ADOC confirmed they were the designated IPAC lead, and they started in the role on the first date of the inspection. The IPAC lead was required to have training in the following areas: infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, outbreak management, asepsis, microbiology, adult education, epidemiology, and program management.

The IPAC lead indicated they were enrolled in an IPAC course and confirmed this was not yet completed. They were unable to provide documented evidence of receiving other education and training in the identified areas.

By failing to have an IPAC lead that had the required training in IPAC practices, placed the home at risk

of not ensuring the appropriate implementation of the IPAC program.

Sources: Interview with IPAC lead. [741757]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that residents with symptoms of infection were assessed on each shift.

Rationale and Summary

The home was declared in an outbreak during a specified period by PH. Review of the clinical records for a number of residents indicated several residents began exhibiting symptoms of infection a number of days before the home was declared in outbreak by PH. Review of the clinical records for those residents indicated they did not have assessments documented on each shift, including vital signs completed for the duration of their infection symptoms.

The previous IPAC lead confirmed the expectation of registered staff was to monitor and assess each resident with symptoms of infection each shift and document in their progress notes and perform daily vital sign screening.

The failure to monitor residents with symptoms of infection on each shift put residents at risk by not determining changes to residents' condition and any subsequent intervention required to support the residents' health and well-being.

Sources: residents clinical records, and interview with an ADOC. [741757]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. i.

The licensee failed to ensure that the report to the Director for an alleged staff to resident #011 emotional abuse incident, included the names of all residents involved in the incident.

Rationale and Summary

A CI was submitted to the Director for an alleged staff to resident abuse incident. The home's investigation revealed a PSW reported additional allegations of abuse or improper care involving the same staff member towards a number of other residents and those residents' names were not identified in the report to the Director. An ADOC confirmed they had not amended the report to the Director to include all residents' names identified in the allegations.

Failing to identify all residents involved in allegations of abuse and or neglect leads to an incomplete investigation.

Sources: CI, home's investigation notes, and interview with an ADOC. [111]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.

1.The licensee has failed to ensure that when required to inform the Director of an incident, that the names of any staff members or other persons who were present at or discovered the incident were included in the report.

Rationale and Summary

A CI was submitted to the Director for a witnessed resident to resident abuse incident. The CI identified an RN as responding to the incident. Review of the health care records for both residents indicated a PSW witnessed the incident and reported the incident to the RN.

The PSW confirmed they witnessed the incident and intervened to separate both residents prior to reporting the incident to the RN. An ADOC acknowledged they did not include the name of the PSW.

Failure to include the names of staff members who were present at or discovered the incident puts residents at risk of harm if those involved were not identified and properly investigated.

Sources: CI, health records for two residents, and interviews with a PSW and an ADOC. [570]

2.The licensee has failed to ensure that when required to inform the Director of an incident, that the names of any staff members or other persons who were present at or discovered the incident were included in the report.

Rationale and Summary

A CI was submitted to the Director for a witnessed resident to resident abuse incident. The CI identified an RPN as responding to the incident. Review of the health records for the two residents indicated the RPN and a PSW intervened and separated both residents. The DOC acknowledged that all staff names were not included in the CI.

Failure to include the names of staff members who were present at or discovered the incident puts residents at risk of harm if those involved were not identified and interviewed.

Sources: CI, health records for two residents, and interview with the DOC. [570]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (3) (b)

The licensee failed to ensure the quarterly evaluation of the medication management system included reviewing reports of any medication incidents, including any incidents of severe hypoglycemia and unresponsive hypoglycemia, the use of glucagon and adverse drug reactions, the factors that contributed to the incident, use of glucagon or drug reaction for a resident.

Rationale and Summary

A CI report was submitted to the Director for a medication incident for a resident involving a hypoglycemic event that required the use of glucagon.

In accordance with O. Reg. 246/22 s. severe hypoglycemia is defined as an incident where a resident is found to have a blood glucose level less than 2.8 millimoles per litre and the resident is conscious. Unresponsive hypoglycemia was defined as an incident where a resident is found to have a blood glucose level less than 2.8 millimoles per litre and the resident is unconscious.

The medication incident list was reviewed and during a specified period there was one severe hypoglycemic event and a number of unresponsive hypoglycemic events where both residents required glucagon and were transferred to hospital.

A review of the medication program, the quarterly medication incident review for the same period was

completed. Under hypoglycemic events, only one glucagon event was identified with no severe and unconscious hypoglycemia events identified. There was no analysis, trends or action plans identified.

The DOC indicated that audits of medication incidents were being completed during the Professional Advisory Committee (PAC) meetings on a quarterly and annual basis. There was no documented evidence to support the review of severe or unresponsive hypoglycemic events in the meeting minutes.

By not conducting a quarterly review of medication incidents of severe and unresponsive hypoglycemia, trends are not identified, and action plans are not created to prevent further occurrence.

Sources: CI, Medication Incident List, Quarterly Medication Incident Review Report and interview with the DOC. [741757].