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
centraleastdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: November 10, 2022	
Inspection Number: 2022-1121-0001	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: MacKenzie Place, Newmarket	
Lead Inspector Asal Fouladgar (751)	**Inspector Digital Signature** Digitally signed by Asal Fouladgar Date: 2022.11.16 14:41:52 -05'00'
Additional Inspector(s) Fatemeh Heydarimoghari (742649) Susan Semeredy (501)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 5-7, 11-14, and 17, 2022.

The following intake(s) were inspected:
- An intake related to responsive behaviour and prevention of abuse.
- Three intakes related to prevention of abuse and neglect.
- An intake related to falls prevention.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Infection Prevention and Control
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 that a person who had reasonable grounds to suspect that abuse or neglect of a resident had occurred, immediately reported the suspicion and the information to the Director.

Rationale and Summary:

A resident reported to Personal Support Worker (PSW) #101 that PSW #100 verbally abused them. PSW #101 communicated the alleged abuse incident to the home's Director of Care (DOC) the next day.

The home's investigation notes indicated that PSW #101 reported the incident to Registered Practical Nurse (RPN) #118 on the same day, and that RPN #118 did not report the alleged verbal abuse to the home's management staff, however they took the resident to the home's DOC's office.

RPN #118 stated they did not verbally report the incident to the home's DOC and that they took the resident to the DOC's office so the resident would self-report the incident to them.

Interim DOC stated that anyone in the home could report any allegation of abuse or neglect to the home's management team. They also confirmed that the resident did not report the alleged verbal abuse to the home's DOC and RPN #118 did not report the incident to the home.

As a result of PSW #101 and RPN #118 failing to ensure a report of abuse and neglect was made, the resident was at risk for further neglect.

Sources: The home's Critical Incident Report (CIR), the home's investigation notes, and interviews with RPN #118 and other staff.

[751]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10 s. 107 (4) (2) (ii)

The licensee failed to ensure that reports made to the Director included the names of any staff members who discovered the incident.

Rationale and Summary

A CIR related to fall and injury of a resident was submitted to the Director. The CIR did not include the name of the staff member who discovered the resident's fall incident. The interim DOC confirmed that this report did not include this information.

Sources: The home's CIR and interview with the interim DOC.

[742649]

WRITTEN NOTIFICATION: Transferring and Positioning Technique

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 36.

The licensee failed to ensure that staff used safe positioning technique when assisted a resident.

Rationale and Summary:

A resident had a fall and sustained an injury. According to the CIR submitted to the Director, the resident appeared to have slid from their assistive device.

The resident's care plan indicated that they required their assistive device to be placed in a specific position. The home's investigation notes indicated that the resident might have been reaching for something and had slid and fell. The home's investigation notes further indicated a recreation aide had assisted the resident with a snack. The recreation aide had placed the resident's assistive device in a different position for eating but did not place them in the required position.

The Recreation Manager acknowledged that the recreation aid failed to use safe positioning technique when assisting the resident. The Interim DOC confirmed that the resident should have been in a proper position in their assistive device to prevent them from falling or sliding out.

Failing to ensure that the resident was safely positioned resulted in a fall and injury.

Sources: The home's investigation notes and CIR, resident's clinical records, and interviews with the Recreation Manager and other staff.

[742649]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

A) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 6.1

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

Rationale and Summary:

In accordance to section 6.1 of the IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, the licensee shall make personal protective equipment (PPE) available and accessible to staff. This shall include having a PPE bin in place for ensuring adequate access to PPE for additional precautions. In addition, under section 9.1, the licensee shall ensure that additional precautions are followed for point-of-care signage indicating that enhanced Infection Prevention and Control (IPAC) measures are in place, including appropriate selection and application of PPE.

Inspector #501 observed that a resident's room had signage on the door for contact precautions. There was no PPE bin hanging on the door. Registered Nurse (RN) #111 confirmed that the resident was on contact precautions and there should have been a PPE bin with supplies hanging from the door. The Interim DOC indicated a registered staff had mistakenly taken the bin down after the resident finished a course of antibiotics.

By failing to comply with infection prevention and control standards and protocols, residents were at risk for becoming ill with an infectious disease, such as, COVID-19.

Sources: IPAC Standard for Long-Term Care Homes, observations, and interviews with the interim DOC and other staff.

B) Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 9.1

The licensee has failed to ensure any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

Rationale and Summary:

In accordance to section 9.1 of IPAC Standard for Long-Term Care Homes issued by the Director, dated April 2022, the licensee shall ensure that additional precautions are followed for point-of-care signage

indicating that enhanced Infection Prevention and Control (IPAC) measures are in place, including appropriate selection and application of PPE.

An observation on the same day indicated a resident was on contact precautions. PSWs #109 and #110 were observed donning PPE prior to performing care for the resident. The PSWs confirmed that the resident was on contact precautions. When donning their PPE, PSW #110 was observed performing hand hygiene then touching their face. The PSW then proceeded to don a gown without performing hand hygiene. The PSW acknowledged their mistake and the Interim DOC confirmed that the PSW should have performed hand hygiene after touching their face.

By failing to comply with infection prevention and control standards and protocols, residents were at risk for becoming ill with an infectious disease, such as, COVID-19.

Sources: IPAC Standard for Long-Term Care Homes, observations and interviews with the interim DOC and other staff.

[501]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee has failed to ensure that the home completed IPAC audits every two weeks as part of the directive issued by the Chief Medical Officer of Health (CMOH).

In accordance with the Minister's Directive, COVID-19 response measures for long-term care homes, homes are to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-term Care Homes in Ontario. This guidance document indicated homes must complete IPAC audits at least every two weeks.

Rationale and Summary:

The home's COVID-19 Self-Assessment Audits during a specific period in year 2022, indicated that only one audit was completed during an identified month. The Executive Director (ED) indicated they were aware that there was a missed audit in that specific month.

Failing to perform IPAC audits at least every two weeks puts residents at risk for infectious disease, such as COVID-19.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes, MLTC COVID-19 Guidance Document for Long- term Care Homes in Ontario, the home's self-assessment audits and an interview with the ED.

[501]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

A) The licensee has failed to ensure a resident was protected from neglect by PSW #114 on March 11, 2022.

Section 5 of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary

On an identified date, evening PSW #101 reported care was not provided to the resident during the day shift. PSW #101 reported that the resident was found sitting in their assistive device in the large dining room since breakfast. The resident was unable to move independently or communicate their needs. PSW #114 admitted that care was not provided to the resident that day because they were short-staffed, and they forgot the resident had been reassigned to them.

Shortly after reporting the incident to the ADOC, the PSW #101 also found that the resident sustained a skin impairment and asked RPN #118 to assess. RPN #118 found that the resident had developed skin impairment and obtained a prescription from the physician for a special treatment. The interim DOC confirmed this incident was a form of neglect as the resident was not provided continence care or repositioned for a whole shift.

As a result of PSW #114 not providing care, the resident developed skin impairment.

Sources: The resident's clinical records, interviews with PSWs #101, #114, RPN #118 and other staff.

[501]

B) The licensee has failed to ensure a resident was protected from abuse by another resident.

Section 2 of the Ontario Regulation 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary

One of the above-mentioned residents had a history of using the other resident's washroom during mealtime as it was closest to the dining room. The Environmental Services Manager (ESM) witnessed both residents yelling at one another in the resident's washroom. Both residents became increasingly agitated and verbally aggressive. One of the residents pushed the other and as a result they fell on the floor and sustained multiple injuries.

As a result of a resident entering another resident's room, an altercation occurred that caused one of the residents to fall and sustained pain and injury.

Sources: The residents' clinical record and interviews with the ESM and other staff.

[501]

(C) The licensee failed to protect a resident from neglect by PSW # 100.

Rationale and Summary

The resident's care plan indicated that they required assistance from staff to complete a specific Activities of Daily Living (ADL) due to their impaired mobility. The resident's clinical records also indicated that they had cognitive impairment and responsive behaviours. The home's investigation notes which included the video camera footage summary, indicated that PSW #100 did not attend the resident's call bell in a timely manner.

PSW #100 stated that prior to the resident's call, they were assisting them with care, the resident suddenly refused care and exhibited responsive behaviour. PSW #100 initiated the "stop approach" and left the resident's room and they did not attend the resident's call bell later as they thought the resident was being attended by another staff.

Interim DOC confirmed that PSW #100 did not answer the resident's call bell in a timely manner and that they should have asked other staff's assistance when the resident initially exhibited responsive behaviours.

There was risk to the resident's well-being and safety when PSW #100 neglected to respond to their call bell.

Sources: The home's CIR and investigation notes, the resident's clinical records, and interviews with PSW #100 and other staff.

[751]

(D) The licensee failed to protect a resident from neglect by PSW #104.

Rationale and Summary

The resident's clinical records indicated they required assistance of one or two staff to complete a specific ADL task. The resident's clinical records indicated that the resident had responsive behaviours.

The home's investigation notes indicated that PSW#104 did not provide care to the resident as the resident was asleep on two occasions and they refused care on the third occasion. The home's investigation notes further indicated that PSW #104 did not check the resident on the third occasion and that their documentations related to the resident's care in Point of Care (POC) were false.

RPN #103 stated that PSW #104 did not report any issues related to providing care to the resident during the night shift.

Interim DOC stated that PSW #104 neglected to provide care to the resident, and they failed to report to the unit charge nurse when the resident refused care.

There was risk to the resident's well-being when PSW #104 did not provide care to the resident during their eight-hour shift.

Sources: The resident's clinical records, the home's investigation notes and CIR, interviews with RPN #103 and the home's interim DOC.

[751]