Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 27, 2016	2015_302600_0024	033217-15	Critical Incident System

Licensee/Titulaire de permis

McKenzie Health
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

Mackenzie Health Long Term Care Facility
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

GORDANA KRSTEVSKA (600), SOFIA DASILVA (567)

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): November 26, December 1 and 2, 2015.

During the course of the inspection, the inspector conducted a tour of the resident home area, observed other residents, reviewed health records, CCAC application records, Policy and Procedures, training records and education materials.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care Clinical (DOCC),Director of Care Administrative (DOCA), Registered Nurses (RNs),Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Clinical Practice Leader-vascular coordinator, and Investigative Coroner.

Ad-hoc notes were used during this inspection.

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents are not neglected by the licensee or staff.

For the purposes of the Act and this Regulation,"neglect" means 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.

Resident's chart record review revealed resident was admitted to the home on an identified date, with chronic health condition. Prior to admission to the home, the resident had been hospitalized for a similar health condition on three instances.

Review of the most recent written plan of care revealed the resident was identified to be at risk for infection related to an identified medical condition. The goal set for this focus in the written plan of care identified the following interventions:
- closely monitor at identified time periods for changes and implement identified strategies if indicated
- discourage resident from sleeping in a specified position
- observe for identified symptoms.

Interview with RN #111 indicated he/she read the care plan but he/she did not know the resident was not to sleep in a specified position.

Interview with RN #106 revealed whenever he/she did rounds, the resident had been sleeping in a position contrary to the written plan of care. The RN further confirmed to have been trained for how to care for the resident's medical condition, but stated, there was nothing in the medication administration record (MAR) for this resident to indicate the resident needed to be monitored. When asked if he/she was aware of the resident's plan of care, the RN confirmed that it would be hard to know all of the residents on the unit and their plan of care. However, usually on admission they check the history of the resident and whatever intervention needs to be done by the registered staff, is entered in the MAR and they follow that. When the RN was asked if this resident was allowed to sleep in a specified position, the RN stated there were no instructions to prevent the resident from sleeping that way. The home policy was presented to the RN, and he/she confirmed that he/she had education about the medical condition but it never came to his/her mind.

Interview with RN #106 revealed that on a few occasions the family had mentioned to him/her about the resident behaviour, but he/she did not ask the family about the resident's history because he/she did not think that it was related to the medical

condition.

Review of the progress notes for eight identified dates, indicated the resident had experienced a change related to the identified medical condition and it was communicated to staff. A review of an identified communication tool indicated the change was communicated to an identified department and physician on two specified dates. The identified department did not address the change. Further review of the identified communication tool indicated the resident had been experiencing this change since admission up until the resident passed away, but the written plan of care indicated no interventions to address this issue and to guide the staff on what to do.

Review of the resident progress notes for two identified months did not indicate why the resident was monitored, how often and what staff had done after they monitored the resident. Interview with RPN #102 identified he/she was looking after this resident same as for everybody else, because there was nothing in the plan of care to direct him/her for specific intervention like how often to monitor or observe the resident.

Review of the progress note from an identified date, indicated resident had a second identified medical condition which was treated. He/she had completed an identified care and treatment. The plan of care decision was the staff to monitor the area for any infection and to follow up. Further record review did not indicate this condition was monitored for infection.

Interview with the Administrator confirmed the home did not have a related lead as the residents with the identified medical condition are managed by a physician in the identified department. The DOC nurse practitioner worked closely with the identified team and staff of the home, and they had been communicating with the physician. Further the administrator confirmed he/she met with the identified department quarterly and discussed any concerns, but this resident was not discussed as of yet as the resident was admitted in a quarter between the meetings. However the administrator was not able to provide the inspector with the notes from the meeting with the department.

The severity of the non-compliance and the severity of the harm is actual.
The scope of the non-compliance is isolated to resident #001.
A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg 79/10., s. 19. (1): A voluntary plan of correction (VPC) was previously issued for O.Reg. 79/10. s.
19. (1) during a Resident Quality Inspection on an identified date, whereby, the licensee

had failed.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out clear direction to the staff and others who provide direct care to the resident.

Resident's chart record review revealed resident was admitted to the home on an identified date, with chronic health condition. Prior to admission to the home, the resident had been hospitalized for a similar health condition on three instances. Review of the resident's written plan of care revealed the staff identified the resident was at risk for change of his/her condition related to medication use during the treatment. The goal set for this focus was the resident would have no incidents of change. Interventions planned for this resident's care were:
- Observe daily for signs and symptoms of change
- Observe the resident for change post treatment.
The written plan of care also revealed the resident was at risk for infection on an identified body part. The goal was resident will have no signs of infection/complication. The interventions set for this focus were:
- Closely monitor post treatment for changes. If change occurs apply intervention, report prolonged changes to department.
- Discourage resident to wear identified items,
- Do not perform an identified medical procedure on the identified body part.
- Monitor and report to the identified department all identified symptoms
- Remove dressing post treatment next morning if dressing still present.
- Watch for any changes. If excessive changes occur apply dressing and call the identified department immediately. Protector to be applied to an identified body part and checked by staff in each shift.
- Staff must be aware that the infection is serious and possibly place resident's life at risk.

Interview with RPN #102 identified he/she was looking after this resident the same as any other resident, because there was nothing in the plan of care to direct him/her to a specific intervention like how often to monitor or observe the resident.

Interview with PSW #103 revealed when the resident was bathed, the PSW would cover the identified body part. He/She confirmed there
was nothing in the written plan of care to direct him/her how to protect the identified area.

Interview with RPN #111 revealed he/she knew the resident had to wear specific type of clothing but he/she was never told why.

This RPN confirmed the plan of care required the resident to be monitored or closely observed and watched, but it was not clear how close and how often. Further the RPN confirmed he/she had tried to observe this resident every identified time, but if the directions were more specific, he/she would have monitored the resident even more often. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Resident's chart record review revealed resident was admitted to the home on an identified date, with chronic health condition. Prior to admission to the home, the resident had been hospitalized for a similar health condition on three instances. Further review of the hospital record faxed to the home on an identified date, revealed resident had been seen by a physician on a specified date, for a change in health condition. After he/she had received three treatments and had been stabilized, he/she had been sent back to his/her home. On another identified date, the resident had been seen by a second physician for a change in health condition. On third identified date the resident had been seen again by a third physician due to concerns regarding inadequate healing of an identified body part from the previous injury.

Review of the progress notes for eight identified dates indicated the resident experienced change on an identified body part and this observation was communicated to an identified department and physician looking after the resident on two identified dates. This issue was not addressed by the department. The staff from the home did not follow up with the department to reiterate the concern regarding changes on the identified body parts.

Interview with RN # 105 confirmed the team at the home was not aware regarding this information. The RN further confirmed they communicated to the department through the identified Communication Tool, but they had not collaborated with the department when the resident was assessed and plan of care initiated. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident, the resident's substitute decisionmaker,if any, and any other persons designated by the resident or substitute decisionmaker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident's chart record review revealed resident was admitted to the home on an identified date, with chronic health condition. Further review of the Mackenzie hospital record faxed to the home on an identified date, revealed the resident had been hospitalized for a similar health condition on three instances. Record review titled Care Conference – Multidisciplinary dated on specified date,
indicated the resident had an admission care conference but no family, SDM or resident participated in the conference.

Interview with the DOC-Clinical confirmed the family should have participated in planning the resident's care. The DOC further confirmed the SDM had known the resident's history from the beginning but they never came forward to share that with the home until the resident passed away.

Interview with RN #105 confirmed the family did not attend the resident care conference on specified date. The RN also confirmed the family had not been approached to participate in planning the resident's care, providing the team with the resident's health history. [s. 6. (5)]

4. The licensee has failed to ensure when a resident is admitted to a long-term care home, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44.

Review of the resident admission assessment record from CCAC of a specified date revealed resident had been recently in a hospital due to an injury after experiencing identified behavior. The record indicated resident's specified behaviour caused damaged and injuries to an identified body part. Review of the resident's written plan of care revealed the information provided by the placement co-ordinator was not considered when the plan of care was developed.

Interview with the RN #105 indicated that he/she was not aware of this information provided by the placement co-ordinator when he/she developed the resident's initial plan of care. The RN confirmed that he/she used the resident assessment record from the CCAC but he/she had missed that information.

Interview with DOC-Clinical confirmed they were not aware of the information in CCAC assessment record for this resident. He/she further confirmed the staff is to use all

available information when developing the resident's plan of care, including the CCAC record. [s. 6. (6)]

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 written plan of care for each resident sets out clear direction to the staff and others who provide direct care to the resident,
to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care,
to ensure when a resident is admitted to a long-term care home, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44, to be implemented voluntarily.

Issued on this 5th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600), SOFIA DASILVA (567)
Inspection No. / No de l'inspection :	2015_302600_0024
Log No. / Registre no:	033217-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 27, 2016
Licensee / Titulaire de permis :	McKenzie Health 10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3
LTC Home / Foyer de SLD :	Mackenzie Health Long Term Care Facility 10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL GRIFFIN

To McKenzie Health, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s.19. (1) to ensure that residents with an identified medical condition are not neglected by the licensee or staff.

The plan must include:
• A process to ensure the initial plan of care is developed based on an assessment of the resident, the assessment, reassessments and information provided by the placement co-ordinator under section 44, and the resident, and the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

• A process to ensure that a written plan of care for each resident sets out, clear directions to staff and others who provide direct care to the resident.

• A process to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The plan is to be emailed to Gordana.Krstevska@ontario.ca on or before February 19, 2016.

Grounds / Motifs :

1. The licensee had failed to ensure that residents are not neglected by the licensee or staff.

For the purposes of the Act and this Regulation,"neglect" means 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.

Resident's chart record review revealed resident was admitted to the home on an identified date, with chronic health condition. Prior to admission to the home, the resident had been hospitalized for a similar health condition on three instances.

Review of the most recent written plan of care revealed the resident was identified to be at risk for infection related to an identified medical condition. The goal set for this focus in the written plan of care identified the following interventions:
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family about the resident's history because he/she did not think that it was related to the medical condition.

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The severity of the non-compliance and the severity of the harm is actual.
The scope of the non-compliance is isolated to resident #001.
A review of the compliance history revealed the following non-compliance

related to the Long-Term Care Homes Act, O.Reg 79/10., s. 19. (1): A voluntary plan of correction (VPC) was previously issued for O.Reg. 79/10. s. 19. (1) during a Resident Quality Inspection on an identified date, whereby, the licensee had failed.
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 19, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gordana Krstevska

Service Area Office /
Bureau régional de services : Toronto Service Area Office