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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 16, 2015	2015_413500_0015	CSC-025618-15	Resident Quality Inspection

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

NITAL SHETH (500), CECILIA FULTON (618), DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 30, October 1, 2, 5, 6, 7, 8, 9, 13, 14, 15, 16, and 19, 2015.

The following complaint inspection intakes were inspected during this RQI: CSC #009317-14, and #001943-15.

The following critical incident (CI) intakes were inspected during this RQI: CSC #025832-15, #009980-14, #009212-14, #006034-14, #003904-15, #003779-15, #028766-15, and T-720-13.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), director of facilities, program manager, dietary manager, registered dietitian (RD), food service supervisor (FSS), director of quality management and infection prevention and control, nursing rehab and RAI coordinator, social worker, physiotherapist (PT), pharmacist, coordinator environmental services, senior human resource coordinator, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), cooks, food service workers (FSWs), food service attendant (FSA), environmental associates, residents, and family members.

During the course of the inspection the inspector(s) conducted observations of residents and home areas, medication administration, meal service delivery, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **3 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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

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

An interview with the Ministry of Health and Long-term Care (MOHLTC) inspector #605 revealed that on an identified day in December 2014, the inspector observed staff #136 yell, very loudly, at resident #035 to stop, when the resident attempted to take something off the staff member's cart. The incident was reported to the Ministry of Health and to the home's administrator by inspector #605.

Record review of the home's incident report and an interview with RPN #137, who witnessed the incident, revealed that RPN #137 immediately addressed staff #136 by saying "you can't speak to resident's that way". RPN #137 confirmed that the manner in which staff #136 spoke to resident #035 was disrespectful.

An interview with staff #136 revealed that he/she does have a loud voice, but that he/she did speak louder to resident #035 that day when the resident was observed taking an item off the staff member's cart. Staff member #136 confirmed that it is very rude to yell at a resident and that he/she would do things differently. [s. 3. (1) 1.]

2. An interview with resident #031 revealed that on an identified day in March 2015, when PSW #139 was assisting him/her back to bed, PSW #139 had asked the resident to reposition him/herself and the resident could not. The PSW referred to the resident as "lazy". Resident interview and a review of the home's investigation revealed that the resident's family member was on the phone, overheard PSW #139 and confirmed that PSW #139 said "you are lazy". Resident #031's family member lodged a complaint with the DOC related to the manner in which PSW #139 spoke to the resident. Resident #031 stated during the interview that the PSW's comments were hurtful.

An interview with PSW #139 revealed that he/she said if you stay in bed you are going to become lazy.

The PSW confirmed that he/she needed to be more careful with his/her words and that the words used to address resident #031 were not respectful.

An interview with the DOC confirmed that the home considered the incident as staff to resident abuse, that disciplinary action was taken and PSW #139 was provided one to one training by the DOC. [s. 3. (1) 1.]

3. A review of a Critical Incident (CI) report revealed that resident #007 reported to the home an incident that occurred on an identified day in September 2015, indicating PSW #115 was verbally abusive while providing care. The resident received a sponge bath on that day. The resident was receiving care and an argument took place between resident #007 and PSW #115 about the care that was being provided. The resident became upset and told PSW #115 to stop lying. That time PSW #115 told the resident "shut up", the resident responded back to PSW #115, "No, you shut up" and PSW #115 repeatedly told the resident to "shut up, shut up".

A review of the home's investigation record revealed that PSW #115's action towards resident #007 was disrespectful and PSW #115 should have respected resident #007's right to be treated with respect and dignity.

Interview with the resident confirmed that PSW #115 told him/her to "shut up" three times while providing care. The resident did not report feeling threatened or afraid after this incident.

Interview with PSW #115 confirmed that he/she told the resident to "shut up" three times while providing a sponge bath, and confirmed that it was his/her mistake. He/she confirmed that he/she should have respected the resident.

Interview with DOC #113 confirmed that during the home's investigation PSW #115 was found to be verbally abusive to the resident, which is not acceptable according to the home's policy on zero tolerance of abuse. The home removed PSW #115 from resident #007's care. Staff are expected to respect residents' right to be treated with respect and dignity. [s. 3. (1) 1.]

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 residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Review of a CI revealed that the home was aware of an incident whereby resident #035 was observed, by an inspector, being yelled at by a staff on an identified day in December 2014. The CI identified the mandatory report category as abuse/neglect. The CI indicated that the home first reported the incident to the Director two days after the incident occurred.

Review of a CI revealed that the home was aware of an incident whereby resident #032 was allegedly pushed by a staff member on an identified day. The CI identified the mandatory report category as abuse/neglect. The CI indicated that the home first reported the incident to the Director three days later.

An interview with the administrator #127 confirmed that the home failed to report resident #032 and #035's allegations of abuse immediately to the Director as required under this legislation. [s. 24. (1) 2.]

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 when a person who has reasonable grounds to suspect that abuse of a resident has occurred shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.
• The Residents' Bill of Rights
• The home's policy to promote zero tolerance of abuse and neglect of residents
• The duty to make mandatory reports under section 24
• The whistle-blowing protections

A review of the home's nursing employee education records and an interview with DOC #113 revealed that 7.6 % of the home's employees did not receive training in the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections in 2014.

A review of the support services environmental employee education record and an interview with coordinator of environmental services #111 revealed that 83.3% of the environmental employees did not receive training in the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections in 2014.

A review of the support services dietary employee education record and an interview with dietary manager #125 revealed that 11% of the dietary employee did not receive training in the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections in 2014, however 100% dietary staff were trained in the Residents' Bill of Rights.

The home was not able to provide education records for support services maintenance employees.

An interview with director facility services (maintenance) #112 and the administrator #127 revealed that 100% of the maintenance employees did not receive training in the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections in 2014.

Interview with administrator #127 confirmed that there is a gap in educating all employees working in the home. [s. 76. (4)]

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 persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.
- ***The Residents' Bill of Rights***
- ***The home's policy to promote zero tolerance of abuse and neglect of residents***
- ***The duty to make mandatory reports under section 24***
- ***The whistle-blowing protections, to be implemented voluntarily.***

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

a.) A review of resident #006's written plan of care and the diet sheet revealed that the resident was to be served an identified item at lunch and dinner.
A review of the home's diet spreadsheet for week 1, Wednesday indicated the same identified item on the menu for the identified diet.

Observation conducted on an identified day, in September 2015, in an identified dining room, revealed that resident #006 was not served the identified item. The inspector did not see PSW#142 refer to a diet spreadsheet while serving the residents.

Interview with PSW #142 confirmed that he/she was not aware that the resident should have receive the identified item.

Interview with FSW #126 confirmed that he/she should have informed the nursing staff that residents receiving the identified diet should be provided the identified item.

Interview with dietary manager #125 and RD #110 confirmed that resident #006 did not receive the diet set out in the plan of care.

b.) A review of resident #021's written plan of care and the diet sheet indicated to provide an identified diet with an identified intervention.

Observation on an identified day, in the identified dining room, revealed that resident #021 was served an entree of the identified diet and not the identified intervention.

Interview with FSW #126 confirmed that he/she served a substitution instead of the identified intervention to resident #021. He/she should have provided an identified intervention as indicated on the diet sheet.

A review of the home's policy #NCM-01-01-06, entitled "Food Production Program", dated July, 2011, indicated diet orders including diet type, diet texture, and fluid consistency, supplement orders and special snack items will be identified on diet listing sheet in order to ensure that each resident receives their proper diet, including specific interventions related to food preferences, dislikes, special need, known allergies and eating assistance devices.

Interview with dietary manager #125 and RD #110 confirmed that resident #021 did not receive the diet set out in the plan of care. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Abuse Policy Number 02-02-02 entitled "Zero tolerance to resident abuse and neglect" dated December 2013, contains an explanation of the duty under section 24 to make mandatory reports.

A review of the home's above mentioned policy, stated that Universal care and the Home shall comply with the LTCHA regulation, s. 24(1) and requires making an immediate report to the MOHLTC Director, where there is a reasonable suspicion that the following incidents occurred or may occur.

-Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
-Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
-Unlawful conduct that resulted in harm or a risk of harm to a resident.
-Misuse or misappropriation of a resident's money.
-Misuse to misappropriation of funding provided to a licensee under the LTCHA or the Local Health System Integration Act, 2006.

Interviews with staff #109, #115, #134, #110, #114, #116, #122,#123, #136, #118, #119, #122 and #121 confirmed an unawareness of their duty to report to the director if they have reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

An interview with the DOC #113 revealed during an inservice education session related to the abuse policy, conducted in May, 2015, staff were directed to make the mandatory report to the DOC or administrator and not to the Director as stated in s. 24 (1). The DOC further confirmed that the above mentioned policy does not contain a full explanation of the duty under section 24 to make mandatory reports with respect to the requirement that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. [s. 20. (2) (d)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

A review of the posted lunch menu in an identified floor satellite dining room in September, 2015, revealed a choice of hamburger with lettuce, tomato and pickle. An observation at 12:00 PM revealed most residents who chose hamburger did not receive lettuce.

A review of the home's policy #NCM-01-01-06, entitled "Food Production Program", dated July 2011, indicated that the nutrition service staff shall follow the planned menu for meals and snacks for all types and therapeutic and texture modifications.

Interview with FSW #126 revealed he/she should have checked the menu before serving the residents and should have called the kitchen to provide the lettuce. The FSW confirmed the hamburgers should not have been served without lettuce. Lettuce was provided after half of the meal service was over.

Interview with dietary manager #125 confirmed that FSW #126 should not serve burgers without lettuce; he/she should get it from the kitchen before serving hamburgers to residents.

Interview with RD #110 confirmed that planned menu should have been offered and available to residents. [s. 71. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

Interviews with resident #001, #003, #007, and #022 revealed that food quality and the taste of food is not good.

a.) A review of the recipe for chicken, drumstick, BBQ did not indicate to marinate the chicken overnight. A review of the recipe for chicken BBQ, minced and pureed indicated to use chicken thigh BBQ- no skin and soup, chicken broth to prepare minced and pureed chicken. A review of the recipe for BBQ sauce revealed that the cook required to prepare BBQ sauce from scratch.

Observation made in October 2015, at 10:50 AM, in the main kitchen, revealed cook #128 portioned out baked marinated chicken drumsticks for the floors. Cook #128 used diced chicken and readymade barbecue (BBQ) sauce for minced and pureed chicken barbecue. The inspector did not observe cook #128 using soup, chicken broth and chicken thigh BBQ for minced and pureed chicken. The inspector did not observe cook #128 measuring ingredients when he/she prepared minced and BBQ chicken, and mashed potato.

Interview with cook #128 confirmed that the chicken drumsticks were marinated overnight in BBQ chicken sauce and he/she had to only bake it. The home always has BBQ chicken sauce, the cook never made it from scratch. Cook #128 indicated that he/she had a standardized recipe but he/she did not follow it as he/she was given instructions to use marinated chicken and he/she was provided diced chicken for minced and pureed. He/she confirmed that the cook always has readymade BBQ sauce.

b.) Interview with food service attendant (FSA) # 129 confirmed that he/she prepared Jell-O lime the day before. He/she confirmed that he/she followed the recipe indicated on the package. He/she used six liters of boiling water to dissolve one pack of jelly powder and portioned it for different floors and stored it in the refrigerator.

A review of the home's recipe for dessert, Jell-O lime, with whipped topping indicated to use boiling water to dissolve gelatin and to add cold water to hot liquid and then to chill it in the refrigerator.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the quarterly evaluation of the medication management system must include at least, reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act.

A review of a Critical Incident revealed in November 2013, two identified medications scheduled for administration to resident #011 were present in the medication cart but had been signed off in the electronic medication administration record as being given.

A review of the home's medication incident report dated January 2015, revealed that in January 2015, a medication incident had occurred involving resident #012.

A review of the Professional Advisory Committee (PAC) meeting minutes of April 2014 did not contain any review of the medication incident involving resident #011.

A review of the Professional Advisory Committee (PAC) meeting minutes of February 2015 did not contain any review of the medication incident involving resident #012.

Interview with administrator #127 confirmed that the home did not review either of these medication incidents at the PAC meetings. [s. 115. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that in addition to the requirement under clause 135 (1) (a), the licensee shall ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b).

Review of a Critical Incident revealed on November 2013 two identified medications, scheduled for administration to resident #011 were present in the medication cart but had been signed off in the electronic medication administration record as being given.

Review of the medication incident report found that the report was incomplete. There was no analysis of the incident and the documentation failed to include any information regarding corrective actions taken.

Interview with administration #127 confirmed that the contents of this incident report were not complete. [s. 135. (2)]

Issued on this 4th day of January, 2016

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

Original report signed by the inspector.