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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2018;	2018_626501_0001 (A1) (Appeal\Dir#: DR# 088)	000885-18, 000944-18, 001901-18, 002647-18	Complaint

Licensee/Titulaire de permis

Mackenzie 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

Amended by Lynne Haves (Director) - (A1)(Appeal\Dir#: DR# 088)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on June 29, 2018.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 088.
A copy of the Director Order is attached.

Issued on this 29 day of June 2018 (A1)(Appeal\Dir#: DR# 088)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2018;	2018_626501_0001 (A1) (Appeal/Dir# DR# 088)	000885-18, 000944-18, 001901-18, 002647-18	Complaint

Licensee/Titulaire de permis

Mackenzie 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

Amended by Lynne Haves (Director) - (A1)(Appeal/Dir# DR# 088)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, February 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 22, 23, 26, 27 and 28, 2018.

During this inspection the following intakes were inspected:

Intake #000944-18 (CIR #2825-000001-18) related to the prevention of abuse and neglect

Intake #000885-18 related to a complaint regarding abuse and neglect, nutrition and hydration, skin and wound care, and transferring and positioning techniques

Intake #001901-18 and #002647-18 related to complaints regarding the plan of care

During the course of the inspection, the inspector(s) spoke with the Administrator, Administrative Director of Care (ADOC), Clinical Director of Care (CDOC), Infection Prevention and Control and Quality Improvement Manager, Registered Dietitian, Outreach Wound Care Specialist, registered staff, personal support workers (PSWs), residents, and family members.

During the course of the inspection, the inspector(s) observed staff and resident interactions and the provision of care, reviewed health records, staff training records, staff personnel files, 2017 complaint incident binder, relevant policies

and procedures and video footage.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition

Infection Prevention and Control

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **7 WN(s)**
- **5 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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian (RD), who is a member of the staff of the home, completed a nutritional assessment for the resident on admission, and whenever there was a significant change in the resident's health condition; and assessed the resident's hydration and any risks related to hydration.

A review of intake #000885-18 revealed that the Ministry of Health and Long-Term Care (MOHLTC) received a complaint from resident #001's family member stating that the resident had on-going hydration concerns.

The Inspector conducted a record review that revealed resident #001 was admitted to the home with a complex medical history. According to a physician's progress note, the resident had been in the hospital for almost a year and the hospitalization was significant for identified medical conditions including hydration concerns and altered skin integrity.

Review of the home's RD's admission assessment revealed the hospital's RD reported an identified hydration status. The home's RD identified that the resident had altered skin integrity. The home's RD calculated that the total fluid the resident would be receiving through all sources would be an identified amount.

An interview with the Clinical Director of Care (CDOC), who is a Nurse Practitioner (NP), revealed resident #001 was admitted with altered skin integrity. During an interview with resident #001's physician they stated that the most significant issue upon admission was the altered skin integrity. The physician also stated that they were aware of the resident's history of hydration concerns.

An interview with the home's RD revealed they had a conversation with the hospital's RD who communicated to the home's RD that resident #001 had an identified hydration status prior to discharge and the home's RD based the admission nutritional assessment on this conversation. According to the home's RD, they did not have access to the hospital laboratory (lab) work but did review the home's admission lab work which was normal. The home's RD calculated that resident #001 needed an identified amount of fluid. The RD acknowledged that a previous history of hydration concerns and altered skin integrity would impact the resident's fluid requirement, accounting for more fluid to meet the resident's needs. The RD confirmed to the Inspector that these contributing factors to the resident's fluid calculation were not considered and in hindsight, the RD admitted that they would have assessed resident #001 to need more fluid.

Progress notes revealed resident #001 developed an identified symptom and the NP ordered medication. Soon after the NP assessed the resident for another symptom and ordered tests. The NP received results that indicated the resident had hydration concerns and sent the resident to the hospital for further treatment and investigation. An NP note stated the hospital diagnosis was a hydration concern as well as, an identified condition related to altered skin integrity.

Review of the home's RD assessment revealed the resident was hospitalized for hydration concerns and the RD increased the total fluid from all sources to be slightly more than the previous order before hospitalization. Interview with the RD acknowledged that altered skin integrity and related complications would impact the resident's fluid requirement, accounting for more fluid to meet the resident's needs. The RD admitted they did not assess these hydration risks.

Review of the hospital's discharge summary indicated that the hospital RD recommended an identified intervention since resident #001's hydration status had improved since admission. During an interview with the home's RD they stated that they did not see this discharge summary and confirmed that this recommendation would provide an identified amount of fluid.

Review of another NP progress note revealed that resident #001 had an identified symptom. The NP and physician ordered an intervention to prevent a hydration issues. Review of another physician progress note revealed the resident had mild hydration concerns. Review of a following RD progress note indicated there was a request from the NP that the physician wanted fluids to be increased and the RD increased the total fluid that the resident would receive.

The Inspector reviewed another physician progress note which identified resident #001 to have an identified symptom and ordered identified tests. Further progress notes revealed the resident continued to have the identified symptom and was started on medication. On an identified date, a physician's progress note identified tests that indicated the resident had hydration concerns and the team needed to push fluids. On the same day, there was a note from the RD that indicated the NP requested the RD to assess results of tests. The RD again increased the total fluid that the resident would be receiving though all sources. A further progress note on the same day indicated an identified intervention was initiated again by the NP.

Review of a further physician's note identified that resident #001's family member

was concerned about the resident's hydration. The physician explained to the family member that there were many reasons for hydration concerns which would include the fact that the resident was having symptoms which would increase fluid requirement. Interviews with PSWs #105, #109 and RPN #110 revealed resident #001 had these identified symptoms regularly.

Review of a progress note made by the RD identified that tests indicated higher than normal ranges and hence to prevent hydration concerns, total fluid from all sources was increased again. A further progress note indicated that the RD had a conversation with resident #001's family member regarding concern that fluid was not always being given as ordered so the RD would be increasing fluid again to prevent hydration concerns.

During an interview with the home's RD they told the Inspector that they could not demonstrate that they considered and accounted for resident #001's continued hydration concerns due to complications related to altered skin integrity. During interviews with the physician and NP they both indicated that they were aware of resident #001's on-going issue with hydration but were at a loss as to why this kept occurring. An interview with the Administrative DOC (ADOC) confirmed that the RD, who is a member of the staff of the home, did not assess resident #001's risks for hydration on admission and upon significant changes in the resident's health condition. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 088)
The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 was provided to the resident as specified in the plan.

A review of intake #002647-18 revealed that resident #001's family member was reporting that a nurse was not giving the resident the required amount of fluid. The family member reported that when reviewing video footage, they noticed that the nurse only gave a quarter of the fluid that they were supposed to give the resident.

Record review revealed resident #001 was admitted to the home with a complex medical history. According to a physician's progress note the resident's hospitalization was significant for many identified medical conditions.

According to the plan of care resident #001 was to receive an identified amount of fluids. This intervention remained unchanged and was still in effect for resident #001's plan of care on the same day as the video footage.

Review of a copy of video footage revealed a staff member was providing fluid to resident #001. The staff member was identified to be RPN #120 by the ADOC. As seen in the video by the ADOC, Inspector #645 and #501, RPN #120 administered less fluid than what was stated to administer in the plan of care.

An interview with RPN #120 and review of the video surveillance revealed they were the staff member in the video and had not provided the required amount of fluids. An interview with the ADOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. A review of intake #000885-18 and #001901-18 revealed resident #001's family member stated PSWs were not putting the resident's identified assistive device on hold and waiting an identified amount of time prior to providing care which was resulting in resident #001 acquiring an identified complication.

On January 29, 2018, resident #001's family member provided two video clips as evidence to support the above allegation.

A review of the plan of care for resident #001 directed PSWs to put the assistive device on hold and wait an identified amount of time prior to providing care.

A review of one video clip revealed that PSW #108 and #123 entered the resident room. PSW #123 put the assistive device on hold and started providing care immediately after without waiting an identified amount of time as the plan of care directed. The second video clip also revealed PSW #124 disconnected the assistive device and provided care immediately after.

During an interview, the Inspector reviewed the first video footage with both PSW#108 and #123. After reviewing of the video footage, both PSWs admitted to having provided care immediately after holding the assistive device. Both PSWs stated that the plan of care for resident #001 directed staff to hold the assistive device and to wait an identified amount of time prior to providing care and confirmed that they did not provide the care as directed on the plan of care. An interview with PSW #124 also confirmed that the care was not provided according to the plan of care.

The ADOC, after reviewing the video footage, indicated that the above mentioned PSWs did not wait an identified amount of time prior to providing care. The ADOC confirmed that the care plan directs PSWs to wait an identified amount of time after holding the assistive device and confirmed that the care was not provided as specified on the plan of care. [s. 6. (7)]

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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

A review of the home's policy #02-01-02 titled Zero Tolerance to Resident Abuse and Neglect last reviewed July 2017, stated, Universal Care and the Home have ZERO tolerance to any type of abuse and neglect of the residents. The policy revealed that hitting, slapping and shoving constitute physical abuse in the resident abuse/neglect indicator table on page 5.

The home's policy further revealed on page 14, that a misuse of power is considered abuse. In order to facilitate the proper use of power, the staff shall create a therapeutic and trusting relationship while maintaining boundaries. The appropriate use of power between staff and residents ensure the resident's needs are foremost and their vulnerability is protected.

A review of intake #000885-18 revealed that on an identified date, resident #001's family member reported to the MOHLTC that there was an incident of staff to resident physical abuse. The incident was seen in video footage. The family member reported that PSW #113 physically abused resident #001.

A review of intake #000944-18 identified that a Critical Incident Report (CIR) was submitted to the MOHLTC on an identified date. It revealed that resident #001's family member was alleging that a staff member had physically abused resident #001. According to the CIR, police were involved and had received video evidence.

During an interview with the Administrative Director of Care (ADOC) they told the Inspector that the police showed them the above mentioned video and it showed that PSW #113 abused resident #001. According to the ADOC, resident #001 was not being resistive.

The Inspector conducted an interview with resident #001's family member. A copy of the video recording was given to Inspectors #645 and #501 and was viewed with resident #001's family member. The recording was date and time stamped and showed PSW #113 in the process of providing care to resident #001. During this process the PSW abused resident #001. Another PSW appeared in the video towards the end of the recording but was unrecognizable.

An interview with the ADOC revealed that the PSW was most likely PSW #105 as this is who PSW #113 worked with on an identified date. An interview with PSW #105 revealed they often worked with PSW #113 but had never seen PSW #113 abusing any resident.

On an identified date, Inspector #645 verified with the police detective at the police station that the video given to the inspectors was the same as the one given to the police.

Record review revealed resident #001 was admitted to the home with a complex medical history. According to a Minimal Data Set (MDS) assessment resident #001 was totally dependent for most activities of daily living requiring two persons assist.

A review of a letter of termination indicated that the home conducted an investigation into allegations that PSW #113 abused a resident and concluded that abuse did occur and PSW #113 would be terminated for cause effective immediately.

PSW #113 failed to create a therapeutic and trusting relationship, subjected a vulnerable resident to their over use of power by abusing resident #001 during care. The licensee failed to ensure that PSW #113 complied with the home's policy

#02-01-02 titled Zero Tolerance to Resident Abuse and Neglect last reviewed July 2017, as required by the legislation. [s. 20. (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 home's written policy to promote zero tolerance of abuse and neglect of residents, is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe positioning techniques when assisting residents.

Resident #001's family member brought forward concerns regarding the staff not using safe positioning techniques that were evident in the video footage provided to Inspectors #501 and #645.

Review of video footage revealed a PSW held resident #001 by an identified body part to turn and reposition the resident. An interview with the Administrative Director of Care (ADOC) revealed this was PSW #122.

The Inspector conducted a record review that identified resident #001 was admitted to the home with a complex medical history. According to a Minimal Data Set (MDS) assessment resident #001 was totally dependent for most activities of daily living.

An interview with PSW #122 and review of the video footage revealed that they held resident #001 by an identified body part, and in doing so, could have caused an injury.

An interview with the ADOC confirmed PSW #122 did not use a safe positioning technique when repositioning resident #001. [s. 36.]

2. Review of video footage revealed that two PSWs left resident #001 unattended while the bed was raised.

Review of video footage revealed PSWs #108 and #128 were providing care to resident #001 and during the care, both PSWs left the resident unattended while the bed was raised. There were no bed side rails.

Interviews and a review of the video footage with both PSW #108 and #128 admitted to have raised the bed and left the resident unattended for an identified amount of time. They both confirmed that they were in the middle of providing care to resident #001 and left the resident unattended. Both PSWs admitted that leaving the resident unattended was unsafe and had put the resident at risk. [s. 36.]

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 staff used safe positioning techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

An email received by the MOHLTC stated that resident #001's family member was concerned that during an identified period of time, resident #001 had an identified level of continence and was at the same time receiving a medication that would be contraindicated.

A record review of the Physician's Orders revealed that the identified medication was prescribed to resident #001 and stated to hold if the resident was having an identified level of continence. Interviews with RPN #110 and the Clinical Director of Care (CDOC) identified that this order meant the medication should be held if the resident was having an identified level of continence.

The Inspector conducted a review of progress notes which identified that resident #001 had an identified level of continence. Review of the Medication Administration Record (MAR) identified that resident #001 was administered an identified medication on the same days by RPN #110.

An interview with RPN #110 revealed it is the home's practice to hold an identified medication if a resident has an identified level on continence.

An interview with the CDOC revealed that they assessed resident #001 for having an identified level of continence and made necessary interventions including identified testing.

Interviews with the CDOC and lead for Infection Prevention and Control revealed that they would have expected RPN #110 to hold the identified medication on the above mentioned days in accordance with the physician's order and best practices. By not holding the medication, the home failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Review of video footage related to intake #000885-18 and other video footage received from resident #001's family member revealed staff were not wearing personal protective equipment (PPE) while providing care.

Review of video footage revealed staff members #120, #122, #126, #127 and #113 were not wearing identified PPE. The staff members were identified by the Administrative Director of Care (ADOC).

Record review and interview with the lead for the Infection Protection and Control (IPAC) program revealed resident #001 had an identified infectious condition.

Review of the home's policy #05-01-07 titled Infection Policy and Guidelines implemented June 2010, indicated that specific PPE should be worn when providing direct care to any resident who has the above identified infectious condition. An interview with the lead for IPAC revealed staff should take contact precautions when providing care to residents with infectious conditions and these contact precautions would include wearing identified PPE.

An interview with the ADOC confirmed that staff members #120 #122, #126, #127 and #113 did not participate in the implementation of the infection prevention and control program. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 received mouth care in the morning and evening.

Review of intake #000885-18 revealed resident #001's family member reported to the MOHLTC that there was an incident where PSW #113 abused resident #001 and this was recorded by video surveillance. Interviews were conducted with other residents in the home regarding the care they received from PSW #113 and resident #003 revealed that PSW #113 would not assist them with mouth care.

During an interview with resident #003 they stated PSW #113 had recently been their primary care giver during the day shift and did not provide oral care. According to the resident, PSW #111 who used to be resident #003's evening primary care giver, was aware PSW #113 did not provide oral care during the day. An Interview with PSW #109 who was recently PSW #113's partner during the day shift, revealed they were aware PSW #113 would not provide oral care for resident #003.

Review of resident #003's plan of care stated that the resident required one staff extensive assistance with oral care.

Review of the home's policy titled "Oral Hygiene" #03-01-018 implemented July 2010, revealed the nursing staff will provide, supervise, remind and cue each resident regularly twice daily oral care and hygiene, including the cleaning of the dentures and natural teeth.

An interview with RN #112 revealed resident #003 needed assistance to brush their teeth and confirmed it is the expectation of the home that PSWs assist residents with oral care at least twice daily. [s. 34. (1) (a)]

Issued on this 29 day of June 2018 (A1)(Appeal/Dir# DR# 088)

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

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West, Suite #303
OSHAWA, ON, L1J-2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest, bureau 303
OSHAWA, ON, L1J-2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by Lynne Haves (Director) - (A1) (Appeal/Dir# DR# 088)

Inspection No. / No de l'inspection : 2018_626501_0001 (A1)(Appeal/Dir# DR# 088)

Appeal/Dir# / Appel/Dir#: DR# 088 (A1)

Log No. / No de registre : 000885-18, 000944-18, 001901-18, 002647-18 (A1) (Appeal/Dir# DR# 088)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 29, 2018;(A1)(Appeal/Dir# DR# 088)

Licensee / Titulaire de permis : Mackenzie 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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

(A1)(Appeal/Dir# DR# 088)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29 day of June 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Lynne Haves (Director) - (A1)
(Appeal/Dir# DR# 088)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Service Area Office / Bureau régional de services : Central East