Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2020	2020_715672_0015	018110-20, 019703-20	Critical Incident System

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

JENNIFER BATTEN (672)

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): October 9, 14-16, 2020

The following intakes were completed during this inspection:

Log #019703-20 - Related to a Critical Incident Report regarding a COVID-19 outbreak in the home.

Log #018110-20 - Related to a Critical Incident Report regarding a resident fall with fracture.

During the course of the inspection, the inspector(s) spoke with the Administrator, Corporate Clinical Consultant, Director of Care for Administration (DOC/Admin), Director of Care for Clinical and Nurse Practitioner (DOC/NP), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapists (PT) and physio assistants (PTA), Housekeepers, Activation Support Workers and residents.

The inspector reviewed clinical health records of identified residents, COVID-19 visitor and staff screening logs, outbreak line lists, Infection Prevention and Control assessments, internal audits, internal policies related to Falls Prevention and Medication Administration. The Inspector also observed staff to resident care and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Safe and Secure Home

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

6 WN(s)
4 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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home is a safe and secure environment for the residents.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTC homes.

During the course of the inspection, the home did not have consistent COVID-19 screening in place at the entrances into the home. The licensee's log indicated that there were incomplete staff and visitor screening prior to entering the home. The DOC/Admin confirmed that there was no designated COVID-19 screener.

Personal protective equipment (PPE) stations outside of resident's rooms on the affected unit did not have adequate PPE items for staff.

On several instances during the course of the inspection, staff were observed to be improperly donning and doffing PPE.

Hand hygiene was not offered or completed for the residents. Staff also did not consistently complete hand hygiene prior to meals and/or during nourishment services.

Physical distancing was not being upheld and staff were observed entering the elevators in numbers higher than was recommended by Public Health. Residents were not maintained to be physically distanced and were placed into small areas in front of a TV for extended periods of times.

The home has not ensured a safe and secure environment for the residents by not following the precautions and procedures that the home is required to follow placing the residents at greater risk of COVID-19 infection.

Sources: Staff, resident and environmental observations conducted by Inspector #672; staff and visitor COVID-19 screening logs completed between eight identified dates; interviews with PSWs #101, #102, #106, #110, #111, amongst others. [s. 5.]

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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's personal health information was kept confidential in accordance with the Personal Health Information Protection Act, 2004.

During resident observations on two identified dates, Inspector #672 noted there was personal health information posted outside of every resident's room on an identified resident home area. During an interview, the DOC/NP indicated the forms had been posted for an identified period of time, after the licensee had initiated a pilot project for Best Practices. The DOC/NP further indicated none of the residents or Powers of Attorney (POAs) had provided informed consent to have the information publicly posted and verified the posted forms breached each resident's confidentiality. Following the interview, the DOC/NP immediately had the forms removed.

Sources: Identified assessment forms for every resident on the identified resident home area, interviews with the DOC/Admin and the DOC/NP. [s. 3. (1) 11. iv.]

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 resident's personal health information is kept confidential in accordance with the Personal Health Information Protection Act, 2004,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the internal Head Injury Routine policy was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 48 (1) the falls prevention and management program is a required organized program in the home.
O. Reg. 79/10, r. 49 (2) states that every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the internal policy related to head injury routines indicated that when a resident was placed on head injury routine assessment, staff were to use the Head Injury Routine form, following the timeframes indicated unless specific physician's orders were received which stated otherwise.

Resident #001 was noted to be at high risk for falls and sustained a number of falls which resulted in the resident being placed on head injury routine (HIR) for each of these falls. Upon review of the head injury routine assessments, the assessments had not been completed in full, as per the directions listed in the internal policy and/or on the head injury routine neurological assessment. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Identified Critical Incident Report, internal policy related to head injury routines, resident #001's Head Injury Routine assessments, interviews with DOC/NP, RNs #114 and #116 and other staff.

Resident #016 sustained a number of falls which resulted in the resident being placed on head injury routine (HIR) for each of these falls. Upon review of the head injury routine assessments, it was noted that none of them had been completed in full, as directed in the internal policy. The DOC/NP reviewed the HIRs completed for resident #016 and verified they had not been completed as directed in the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Internal policy related to head injury routines, resident #016's Head Injury

Routine assessments, interviews with DOC/NP, RNs #114 and #116 and other staff.

Resident #017 sustained a number of falls which resulted in the resident being placed on head injury routine (HIR) for each of these falls. Upon review of the HIR assessments, it was noted that none of them had been completed in full, as directed in the internal policy. During an interview, the DOC/NP verified that the HIR assessments were not fully completed. The DOC/NP also indicated that the expectation in the home was for HIR assessments to be completed as per the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Internal policy related to head injury routines, resident #017's Head Injury Routine assessments, interviews with DOC/NP, RNs #114 and #116 and other staff.

Resident #018 sustained a number of falls which resulted in the resident being placed on head injury routine (HIR) for each of these falls. Upon review of the HIR assessments, it was noted that none of them had been completed in full, as directed in the internal policy. During an interview, the DOC/NP verified that the HIR assessments were not fully completed. The DOC/NP also indicated that the expectation in the home was for HIR assessments to be completed as per the internal policy. By not completing head injury routine assessments appropriately, residents were placed at risk of head injuries not being identified and/or treated appropriately.

Sources: Internal policy related to head injury routines, resident #018's Head Injury Routine assessments, interviews with DOC/NP, RNs #114 and #116 and other staff.
[s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that lunch meals were served to residents at a palatable temperature.

The home was declared to be in a COVID-19 outbreak and as a result, some residents were isolated to their rooms and received meals via tray service. An observation of the lunch meal noted the meals were being served on disposable paper plates and drinks were served in disposable cups, none of which were covered. The food and fluids were then placed on plastic cafeteria style trays and served to the residents in their bedrooms. During the meal observation, resident #014 complained that they could not enjoy their lunch meal, due to it being served cold. Resident #014 indicated that since the licensee had moved to tray service, they had experienced multiple meals served at unpalatable temperatures for breakfast, lunch and dinner, due to the foods becoming too cold to enjoy. Resident #014 indicated that staff were not following up with residents during meals to assess how they were doing or inquire if any assistance was required, such as offering to reheat a meal. Resident #013 also indicated they did not enjoy the food or hot fluids due to the temperatures being too cold. Resident #013 verified the information provided by resident #014, related to experiencing multiple meals served at unpalatable temperatures for breakfast, lunch and dinner due to the foods being too cold to enjoy, since receiving tray service. After receiving assistance with their meal, resident #012 indicated that the meal was not at an enjoyable temperature, due to the meal and hot beverages being served cold. During separate interviews, PSWs #101, #102 and #110

indicated the procedure staff were following was to serve meal trays, which consisted of uncovered meals being served on disposable plates/cups to any resident on the unit who could not attend the dining room. Once each resident had received their meal tray, staff would then assist the residents who required physical assistance with their meals. These staff members stated that since tray service was initiated for multiple residents during the outbreak, they had heard complaints that the foods were not being served at the temperatures they should be. By serving meals to residents at unpalatable temperatures, residents were at increased risks of having poor food and fluid intakes.

Sources: Inspector observations; interviews with residents #012, #013 and #014; staff interviews with PSWs #101, #102 and #110 amongst others. [s. 73. (1) 6.]

2. The licensee failed to ensure that lunch meals were not served to residents #004, #005, #006, #007, #009 and #012 until a staff member was present to assist the residents with their meals.

The home was declared to be in a COVID-19 outbreak and as a result, some residents were isolated to their rooms and received meals via tray service. An observation of the lunch meal noted the meals were being served to each of the residents who remained in their rooms, and then staff began assisting the residents who required physical assistance with their meals. This led to some residents having meals served to their rooms for 20 to 45 minutes prior to receiving the required assistance from staff to consume their lunch meal.
Residents #004, #005, #006, #007, #009 and #012, all of whom required physical assistance with meals, had their lunch meals served to them prior to a staff member being available to provide the required assistance. During separate interviews, PSWs #101, #102 and #110 indicated the procedure staff were following was to serve meal trays to every resident on the unit first and then begin assisting the residents who required assistance with their meals. By serving meals to residents prior to someone being available to provide the assistance required, resident’s emotional health and dignity may be negatively affected, along with increased risks of poor food and fluid intakes.

Sources: Inspector observations; written plans of care for residents #004, #005, #006, #007, #009 and #012; staff interviews with PSWs #101, #102 and #110 among others. [s. 73. (2) (b)]

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 meals are served to residents at palatable temperatures and only when a staff member is present to assist the resident with their meal, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

During resident observations of resident #001's environment on two identified dates, an identified number of medications and/or medicated creams were left unsecure in the resident's bedroom and bathroom. Two other random resident rooms were observed and resident #002 had a number of medicated creams left unsecure in the resident's bedroom and resident #003 had a number of medicated creams left unsecure in the resident's bedroom. RPNs #100 and #105 and DOC/NP stated that Registered staff administered all medications and medicated creams in the home, no resident had been assessed as able to self administer any medications or medicated creams and the expectation in the home was for all medications and medicated creams to be kept secured in the medication or treatment carts immediately following administration. Following the interview, DOC/NP indicated every resident room would be searched and all medications and medicated creams would be removed. On an identified date following the interview, Inspector #672 conducted a follow up observation of resident #001's environment and noted there was still a specified number of medicated creams left unsecure in the resident's bathroom.

Sources: Observations of resident #001, #002 and #003's environment, staff interviews with RPNs #100, #105 and with the DOC/NP. [s. 129. (1) (a)]

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 medications and medicated creams are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure the Director was immediately notified of a COVID-19 outbreak being declared by Public Health.

A COVID-19 outbreak was declared in the home on an identified date, after Public Health was contacted the day prior, when the licensee had been notified a staff member had tested positive for the illness, and there were multiple residents in the home exhibiting one or more symptoms of the illness. During an interview, the DOC/Admin indicated they were responsible for overseeing the Infection Prevention and Control program in the home and submitting the Critical Incident Report to the Director. The DOC/Admin further indicated that with all of the busyness and confusion going on in the home around that time, they had missed immediately informing the Director of the declared outbreak, and submitted the Critical Incident Report two days later.

Sources: Identified Critical Incident Report related to the COVID-19 outbreak, interview with DOC/Admin. [s. 107. (1) 5.]

Issued on this 23rd day of October, 2020

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

Original report signed by the inspector.