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
Jul 27, 2021	2021_784762_0018	003705-21, 004546-21, 004547-21, 004548-21, 005913-21, 007021-21, 008274-21, 009073-21, 009077-21	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

MOSES NEELAM (762)

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): June 23 - 25, 28 -30, July 5 -9 and 12-13, 2021

The following intakes were completed in this Critical Incident System (CIS) and Follow up inspection:
- Log/ CIS, related to an incident that lead to an injury for which the resident was taken to the hospital and had a significant change
- Log/ CIS, related to an incident that lead to an injury for which the resident was taken to the hospital and had a significant change
- Log/ CIS,, related to an incident that lead to an injury for which the resident was taken to the hospital and had a significant change
- Log/ CIS,related to another log, in which the complainant alleged abuse/neglect
- Log related to infection control and temperatures in the Long-Term Care Home (LTCH)

The following intake was completed in the Critical Incident System Inspection:
Log/CIS was related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, IPAC lead, Physiotherapist (PT), Nurse Practitioner Director of Care (NPDOC), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeeping Staff and Personal Support workers (PSWs)

During the course of this inspection the inspector observed infection prevention and control practices, monitoring of air temperature, resident and staff interactions, and conducted observation on resident home areas

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #003	2021_715672_0007	762
O.Reg 79/10 s. 73. (1)	CO #002	2021_715672_0007	762
O.Reg 79/10 s. 73. (2)	CO #001	2021_715672_0007	762

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 O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home

A review of the LTCH's documented temperature records was conducted. During this review, it was noted that temperatures were not measured and documented in two different rooms in two different parts of the home. Review of an email between Administrator #103, Staff #110, DOC #104, and Staff #111, indicated that the temperature logs were not being recorded. In separate interviews, Administrator #103 and DOC #104 confirmed the temperature was not measured as it was not recorded. Failing to ensure that the temperature was measured and documented in two different rooms in different parts of the home increased the risk of heat related illness for the residents.

Sources: temperature logs; Email; Interview with Administrator #103; Interview with DOC #104 [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperature was measured and documented in resident common areas including, the lounge, dining, or corridor.

A review of the LTCH's documented temperature records was conducted. During this review, it was noted that temperatures were not measured and documented in resident common areas including, the lounge, dining, or corridor. Review of an email between Administrator #103, Staff #110, DOC #104, and Staff #111, indicated that the temperature logs were not being recorded. In separate interviews, Administrator #103 and DOC #104 confirmed the temperature was not measured as it was not recorded. Failing to ensure that the temperature was measured and documented in the common areas increased the risk of heat related illness for the residents.

Sources: temperature logs; Email; Interview with Administrator #103; Interview with DOC #104 [s. 21. (2) 2.]

3. The licensee has failed to ensure that the temperatures were required to be measured under subsection (2) documented once every morning, once every afternoon between 12 p.m. and 5 p.m and once every evening or night.

A review of the LTCH's documented temperature records was conducted. During this review, it was noted that temperatures were not being measured and documented once every morning, once every afternoon between 12 p.m. and 5 p.m and once every evening or night, in two resident rooms in two different parts of the home and in resident common areas including, the lounge, dining, or corridor. Review of an email between Administrator #103, Staff #110, DOC #104, and Staff #111, indicated that the temperature logs were not being recorded. In separate interviews, Administrator #103 and DOC #104 confirmed the temperature was not measured as it was not recorded. Failing to ensure that the temperature was measured and documented once every morning, once every afternoon between 12 p.m. and 5 p.m and once every evening or night, in two resident rooms in different parts of the home and in resident common areas including, the lounge, dining, or corridor increased the risk of heat related illness for the residents.

Sources: temperature logs; Email; Interview with Administrator #103; Interview with DOC #104 [s. 21. (3)]

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 ensure that the temperature measured and documented in writing in at least two resident bedrooms in different parts of the home, common area and that temperatures are measured and documented once in the morning, between 12 PM and 5 PM, and in the evening or night, to be implemented voluntarily.

Issued on this 28th day of July, 2021

[redacted]

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

Original report signed by the inspector.