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
Sep 28, 2021	2021_718535_0018	010893-21, 014196-21	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

VERON ASH (535), FRANK GONG (694426)

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): September 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 2021.

The following intakes were completed during this inspection:

Log #010893-21 was related to falls, and
Log #014196-21 was related to abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care - Clinical and Administration (DOCs), Physiotherapist (PT), registered staff (RN/RPN) and personal support workers (PSWs).

During the course of the inspection, the inspectors conducted observations on all resident home areas, observed resident to resident and staff to resident interactions, reviewed clinical health records, staff schedules, internal investigation records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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	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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident fell on an identified date, staff involved in different aspects of care collaborated with each other so that their assessments were integrated, consistent with, and complemented each other.

The home required registered nursing staff to collaborate with the interdisciplinary team when a resident exhibits a change in health status or pain is not relieved by initial interventions.

Following the resident's fall, they indicated pain radiating from identified body parts on specific dates, however, no interdisciplinary referrals were made by the registered nursing staff to the home's Physiotherapist. A skin integrity concern was observed on a specific body part; however, no interdisciplinary referrals were made to the Physiotherapist. The resident was transferred to hospital for further assessment and was diagnosed with a specific injury.

The Physiotherapist verified that referrals were not received when the resident expressed pain and exhibited an alteration in skin integrity to a specific body part. It was indicated that if a referral was received, the follow-up action would be to requisition an x-ray to rule out injury. The DOC acknowledged that a physiotherapy referral should have been made and that there was a lack of interdisciplinary collaboration in the resident's assessment.

Failure to ensure that staff involved in different aspects of care collaborated with each other may result in a delay in receiving treatment, further injury, and unnecessary pain.

Sources: CIS Report, Resident's assessments, care plan, hospital report, and progress notes, Falls Prevention and Management Policy, Pain Management Policy, interviews with the RN, RPN, Physiotherapist and DOC.

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, 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 the alleged emotional abuse of the resident, and the information upon which it was based was immediately reported to the Director.

The resident submitted a written complaint to the home which stated that an identified PSW performed an inappropriate gesture to the resident when the resident made a requested.

The DOC investigated the incident; and reported that the resident and family were satisfied with the outcome of their investigation although abuse was unfounded. They also acknowledged that the alleged emotional abuse was reported late to the Director.

Source: CIS report, and an interview with the DOC.

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 immediately report all alleged abuse of residents and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents have an unwitnessed fall, the Head Injury Routine (HIR) monitoring assessments were documented according to the Home's Falls Prevention and Management Program.

The Home's Falls Prevention and Management Program required the HIR monitoring to be completed for any unwitnessed falls; documented at time intervals specified by the Home.

A review of the first resident's HIR monitoring record was completed. An interview with the RN and DOC verified that the HIR monitoring records documented were inconsistent with what was specified by the Home's policy.

Sources: Resident's progress notes, HIR monitoring forms, Falls Prevention and Management Policy, Head Injury Routine Policy, interview with the RN and DOC.

2. A review of the second resident's HIR monitoring record was completed. The DOC verified that the HIR monitoring records documented were inconsistent with what was specified by the Home's policy.

Sources: Resident's progress notes, HIR monitoring forms, Falls Prevention and Management Policy, Head Injury Routine Policy and interview with the DOC.

3. A review of the third resident's HIR monitoring record was completed. And, again the interview with the home's DOC verified that the HIR monitoring records documented were inconsistent with what was specified by the Home's policy.

Failure to ensure that HIR assessments were documented according to the Home's Falls Prevention and Management Program may result in missed assessments and a delay in treatment if residents sustained a head injury.

Sources: Resident's progress notes, HIR monitoring forms, Falls Prevention and Management Policy, Head Injury Routine Policy, Head Injury Routine Policy and interview with the DOC.

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 actions taken with respect to a resident under a program are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident expressed pain, they were assessed using a clinically appropriate assessment instrument.

The Home requires that a resident be assessed for any new pain or pain related to changes in medical condition using the appropriate pain assessment record.

Following the resident's fall on an identified date, they indicated ongoing pain over a period of time; however, no clinically appropriate pain assessments were documented during that period. The resident was transferred to the hospital for further assessment and was diagnosed with an injury.

The RN verified that a clinically appropriate pain assessment was not completed when the resident expressed ongoing pain. The Physiotherapist noted that following a fall, new pain would be a concern that required assessment. The DOC verified that when the resident expressed pain, a clinically appropriate pain assessments should have been completed but were missed.

Failure to ensure that when a resident expressed pain, they were assessed by a clinically appropriate pain assessment instrument may result in unnecessary pain, delay in receiving treatment, and further injury.

Sources: CIS Report, Resident's assessments, hospital report, and progress notes, Pain Management Policy, and interviews with the RN, RPN, Physiotherapist and DOC.

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 resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #5: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of an incident with injury, that resulted in the resident's transfer to hospital and a significant change in health condition.

The resident fell and was sent to hospital on an identified date. They returned to the home on the same day with a diagnosed injury. The critical incident report was submitted to the Director on a later date.

The DOC acknowledged that the CIS report was submitted late, and the incident should have been reported the next day.

Sources: CIS Report, resident's hospital report and progress notes, interview with the DOC.

Issued on this 28th day of September, 2021

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

Original report signed by the inspector.