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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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_0017	011517-21, 011712-21, 012303-21	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

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, offsite 23, 24, 2021.

The following intakes were completed during this inspection:

Log #011517-21 was related to personal care,
Log #011712-21 was related to unexpected death, and
Log #012303-21 was related to improper care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care - Clinical and Administration (DOCs), IPAC Lead/Quality Manager, Office Coordinator, Physiotherapist (PT), Recreation Manager, registered staff (RN/RPN) and personal support workers (PSWs) and substitute decison-makers (SDMs).

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:
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's clinical health records were kept in a readable and usable format that allow a complete copy of the record to be readily produced.

During the onsite inspection, the inspector requested the resident's paper chart for review. The home's Administrator produced the chart which was taken apart to be filed since the resident died. The resident's chart did not contain a specific document related to the procedure which was performed earlier on the same date the resident died.

The RPN confirmed that they had reviewed the document with the RN when the resident returned from the hospital to the long-term care home.

The home's Administrator and Clinical DOC verified that the document was not found in the resident's current chart.

Therefore, the licensee failed to ensure the resident's health records were kept in a readable and usable format that allowed for a complete copy to be readily produced.

Source: Resident's paper chart and interview with RPN, DOC and Administrator.

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 resident's records were kept in a readable and usable format that allow a complete copy of the record to be readily produced, to be implemented voluntarily.

WN #2: 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 the resident receive oral care to maintain the integrity of the oral tissue, including mouth care in morning, evening and as needed.

The resident was assessed by the home and was being fed as per the physician and dietitian. The resident's substitute decision-maker (SDM) indicated that the resident was lacking proper oral hygiene.

Record review of the resident's written care plan revealed that the resident required total assistant to complete oral care and that no frequency of care was included. The resident's electronic medication administration record (eMAR) indicated that they had a prescribed medication to support their oral care, however, during a specific monitoring period, it was noted that registered staff did not sign the medication in the resident eMAR to indicate use of the product.

The resident's primary care PSW and RN both verified that the resident required additional oral hygiene and that they would have benefited from the use of the prescribed product. The RN also verified that the physician was not consulted regarding the resident's oral hygiene.

Sources: Resident's written care plan, EMAR, POC records and interviews with the PSW and RN.

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 residents receive oral care to maintain the integrity of the oral tissue, including mouth care in morning, evening and as needed, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's plan of care was based on an assessment of the resident's needs and preferences.

The resident was assessed by the home. However, a review of their written care plan indicated that their specified preferences were not included.

During an interview, the RN verified that the resident's preferences were not included in their plan of care. They indicated that they would have a discussion with the resident and enter the information in the written care plan based on the resident's preferences.

Sources: Resident's written care plan and interview with the RN.

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.