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
Mar 31, 2022	2022_919026_0004	014536-21, 015619-21, 017704-21, 000798-22	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

JULIE DUNN (706026), AMA AGYEMANG (722469)

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): March 14, 15, 16, 17 and 18, 2022.

The following intakes were completed in this critical incident inspection:

Log #000798-22 CIS 2825-000002-22 was related to falls management;
Log #014536-21 CIS 2825-000027-21 was related to falls management;
Log #015619-21 CIS 2825-000029-21 was related to Medications; and
Log #017704-21 CIS 2825-000031-21 was related to Prevention of Abuse, Neglect and Retaliation.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Staff, the Infection Prevention and Control (IPAC) Lead, and the Director of Care (DOC).

During the course of the inspection, the inspectors toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 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 person, who had reasonable grounds to suspect that any abuse of a resident that resulted in a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director. LTCHA s. 24. (1)

A family member of a resident notified the former Administrator and the former DOC of the home of an allegation of abuse. The home did not immediately submit the allegation of abuse as a critical incident (CI) . The DOC verified that the allegation of abuse should have been reported as a CI at the time of receiving notification from the resident's family member.

Sources: Interview with DOC, CIS report, internal records from the home. [s. 24. (1)]

WN #2: 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 failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program. O. Reg. 79/10 s. 229. (4)

The long-term care home expected all staff and visitors to have universal masking and eye protection. On multiple occasions on different dates, there were staff and visitors in the home who were not wearing eye protection.

For the lunch meal in a dining room, there was no hand hygiene done by the residents, and staff did not assist any residents with hand hygiene. Several residents ate their lunch independently, using utensils to eat soup and salad, and using their hands to eat cheese sandwiches. Hand hygiene for residents is to be done before and after meals.

Failing to provide or assist residents with hand hygiene posed a risk of spread of infection.

Sources:
Observations, interviews with staff, Infection Prevention and Control Program Policy, dated December 2019. [s. 229. (4)]

Issued on this 5th day of April, 2022

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

Original report signed by the inspector.