Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: April 17, 2023	
Inspection Number: 2023-1310-0001	
Inspection Type: Critical Incident System	
Licensee: Mackenzie Health	
Long Term Care Home and City: Mackenzie Health Long Term Care Facility, Richmond Hill	
Lead Inspector Sheri Williams (741748)	**Inspector Digital Signature** Sheri A Williams Digitally signed by Sheri A Williams Date: 2023.04.27 14:45:48 -04'00'
Additional Inspector(s) Carole Ma (741725) Lucia Kwok (752) was present during the inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27- 30, and April 3, 2023
The inspection occurred offsite on the following date(s): March 31, 2023

The following intake(s) were inspected:

- Two intakes related to fall with injury incidents

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure a resident's plan of care for falls interventions was updated when the care set out in the plan was no longer necessary.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director for a fall incident resulting in an injury.

The resident's plan of care documented specific interventions for falls prevention interventions. During the inspection, these interventions were not observed to be in place. Multiple staff confirmed they were no longer in place as the resident no longer required the interventions.

Staff failed to revise the resident's plan of care when their care needs changed, which placed the resident at low risk to their quality of life for not providing for their current needs.

Sources:
Clinical record, Observations, Interviews with staff.

[741748]

WRITTEN NOTIFICATION: ELEVATORS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 13

The licensee has failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

Rationale and Summary

The Long-Term Care Home (LTCH) occupied three floors of a larger health care facility. It has three

designated elevators, one of which is a service elevator. The inspectors were informed that there were no security codes required to take the elevators.

The inspectors observed that residents had unrestricted access to all floors of the home and larger facility, as reflected by the elevator control panel displaying five floors (G, 2, 3, 4, 5). Despite signage posted inside the elevators that the ground floor could not be accessed due to construction, the elevator doors still opened to this site.

Further, through the service elevator's rear door, residents had unrestricted access to four storage rooms within the LTCH and the larger facility itself, some of which were stocked with clinical supplies, carts of laundry and disposal bins. One storage room had a sign posted for staff to not place bags of clothing against transformers that felt hot to the touch. Each of the supply rooms also had a second door that connected to a main hallway.

The home did have residents who exhibited wandering behaviours wear a WanderGuard bracelet which restricted them from elevator access. However, the Administrator acknowledged that other residents could access restricted areas of the construction site, storage and supply rooms. They recognized the potential risk of residents entering these areas.

In failing to adequately secure the elevators, residents were potentially at risk of entering unsafe restricted areas.

Sources: Observations, interview with Administrator.

[741725]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident's altered skin integrity was assessed using a clinically appropriate skin and wound assessment instrument by a registered nursing staff.

Rationale and Summary

A CIR was submitted to the Director related to a resident's fall that resulted in a significant change in health and an altered skin integrity. The resident's medical records revealed the altered skin integrity was not documented using the home's skin and wound assessment tool. An RN and DOC also confirmed

this through their own record review.

A DOC stated that establishing a baseline of the altered skin integrity would provide a useful comparison if complications to wound healing had occurred. They stated that education would be provided to the RN.

By not using the skin and wound assessment tool for the resident's altered skin integrity, the home missed a key moment in best practice for monitoring a new area of altered skin integrity.

Sources: CIR, resident's medical records, interviews with staff and DOC.

[741725]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure when a resident's pain was not relieved by the initial intervention, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

A CIR was submitted to the Director related to a resident's fall incident. During this incident, the resident made expressions of severe pain and was administered a pain medication, which on follow-up was recorded as being ineffective. The resident was later found to have sustained an injury resulting from the fall.

The resident's medical records revealed their pain was not reassessed using the home's pain assessment tool when the pain medication was determined to be ineffective. An RN and DOC also confirmed this through their own record review.

The home's policy on pain assessment stated where pain is not relieved by initial interventions, registered nursing staff were to collaborate with resident/SDM, family and interdisciplinary team to conduct the pain assessment utilizing a clinically appropriate instrument for pain assessment. Further, the pain assessment tool was to be completed when pain management strategies were no longer effective.

By not using the pain assessment tool for the resident after the initial intervention was determined to be ineffective, potential interventions may have been overlooked and the resident continued to experience unmanaged pain and emotional distress.

Sources: CIR, resident's medical records, interviews with staff and DOC, Pain Assessment Policy.

[741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

1. Non-compliance with: O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard, section 9.1 (d) routine practices

The licensee failed to ensure that routine precautions of masking were followed in accordance with any standard or protocol issued by the Director.

Rationale and Summary

In accordance with the IPAC Standard for Long Term Care Homes issued by the Director, dated April 2022, section 9.1. (d) states at minimum, routine practices shall include proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

On two different occasions, visitors were observed not wearing their medical mask properly in a communal dining room with other staff and residents in the surrounding. A contract staff member was observed in the servery area with their mask pulled down around their neck near other staff. They acknowledged the home was in a COVID-19 outbreak and they were aware to wear a mask at all times.

The DOC confirmed that universal masking was mandatory, and their mask should cover their nose and mouth, stating there would certainly be risk if they are carrying anything communicable, they would pass it on readily.

Failure to ensure masking requirements were followed may lead to the transmission of infection.

Sources: Observations and Interview with DOC.

[741748]

2. Non-compliance with: O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard, section 6.1

The licensee failed to ensure that Personal Protective Equipment (PPE) was available and accessible in accordance with any standard or protocol issued by the Director.

Rationale and Summary

In accordance with the IPAC Standard for Long Term Care Homes issued by the Director, dated April 2022, section 6.1 states the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for routine practices and additional precautions.

During the inspection, the LTCH was declared in COVID-19 outbreak. In two residents' rooms placed on additional precautions, there were no gowns observed in the PPE caddies.

The IPAC lead stated there is a process for ensuring PPE caddies are stocked with sufficient and appropriate PPE and this was not in place. The DOC confirmed there was no reason why gowns were not in isolation caddies.

Failing to ensure PPE is available and accessible to staff and visitors causes increased risk of transmission of COVID-19 infection during the outbreak.

Sources: Observations and interviews with IPAC lead and DOC.

[741748]

3. **Non-compliance with: O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard, section 9.1(f) additional precautions**

The licensee failed to ensure that PPE was removed and disposed in accordance with any standard or protocol issued by the Director.

Rationale and Summary

In accordance with the IPAC Standard for Long-Term Care Homes, April 2022, section 9.1. (f) states the licensee shall ensure that at a minimum, additional precautions for PPE shall include appropriate selection application, removal, and disposal.

On the date the COVID-19 outbreak was declared, garbage hampers for doffing PPE were observed outside resident rooms on additional precautions. In speaking with the IPAC lead about this concern they confirmed that PPE should be doffed inside resident rooms. On a subsequent observation there continued to be three rooms on additional precautions with garbage hampers set up outside of the resident rooms for doffing PPE.

The DOC confirmed that PPE should be doffed inside resident rooms to prevent the spread of infection.

Failing to ensure that additional PPE requirements are removed and disposed in the appropriate area for doffing increases risk of transmission of COVID-19.

Sources:
Observations, Interviews with IPAC lead and DOC.

[741748]