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

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Original Public Report

Report Issue Date: August 21, 2024

Inspection Number: 2024-1310-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Mackenzie Health

Long Term Care Home and City: Mackenzie Health Long Term Care Facility, Richmond Hill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6 - 9, 12 - 16, 2024.

The following intakes were completed in this complaint inspection:
An intake related to staffing plan and resident care and services.

An intake related to residents' rights and choices, resident care and support services, and safe and secure home.

The following intakes were completed in this Critical Incident (CI) inspection:
An intake was related to an allegation of staff-to-resident abuse and neglect.

An intake was related to food, nutrition, and hydration.

An intake was related to a fall with significant change in health condition.

An intake was related to safe and secure home.

An intake was related to resident care and support services.

An intake was related to residents' rights and choices, resident care and support services, and safe and secure home.

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Resident Care and Support Services
Residents' Rights and Choices
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that the resident's choices related to a medical procedure were respected.

Rationale and Summary

A Critical Incident Report (CIR) and a complaint concerning an outcome of the resident were submitted to the Director.

The resident's care plan had indicated a specific choice to be followed should they were found in a specific health condition. The choice was documented on a specific form, as well as the resident's electronic health records.

On one day, the resident was found to be in a specific health condition. Emergency service was contacted, and the team arrived shortly after. The document containing the resident's specific choice was provided but the team did not accept the choice as the document was not fully completed. As such, the team proceeded with performing a procedure. The nursing team had further reviewed the document and inserted additional information. The form, alongside with the resident's desired choice, was then accepted by the emergency services.

Interviews with multiple registered staff and management confirmed that the resident's choice was not respected and honored when the identified document was not fully completed.

With the identified non-compliance, the resident had to be on the floor until they were examined by an external health care professional.

Sources: the resident's clinical record, emergency services incident reports, interviews with the nursing staff and others.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the resident's personal health information (PHI) was kept confidential in accordance with the Personal Health Information Protection Act, 2004.

Rationale and Summary

A CIR and a complaint concerning an outcome of the resident were submitted to the Director.

A resident was being prepared to be sent to a local medical facility. When emergency services arrived, the registered staff had handed over medical documents that belonged to another resident. Therefore, exposing the resident's personal health information to the team.

The registered staff and the Administrator acknowledged the error and the incorrect documents were later returned to the long-term care home (LTCH).

The resident was not affected by this error as their PHI was retrieved by the LTCH.

Sources: the resident's clinical record, emergency services incident reports, interviews with registered nursing staff and others.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee has failed to ensure that a person that had reasonable grounds to suspect improper or incompetent care or treatment of the resident was immediately reported to the Director.

Rationale and Summary

A CIR was submitted to the Director indicating an agency Personal Support Worker (PSW) had incorrectly applied a transfer device on the resident and the staff was subsequently sent home the same morning.

As per the home's internal investigation notes, a registered staff was alerted to assess the resident one morning as a transfer device was incorrectly applied on the resident. At that time, the resident was assessed and no injuries were identified. The identified agency PSW was then sent home. The registered staff had also contacted an On-Call Manager of the matter.

As per the CIR, the incident was not reported to the Director until days later.

An interview with the Director of Care (DOC) Administration confirmed that the incorrect application of the transfer device was a case of improper or incompetent care and treatment which required immediately reporting to the Director. The DOC Administration further confirmed that the matter was reported late to the Director.

There was no direct risk to the resident as a result of the non-compliance.

Sources: CIR, the resident's electronic and non-electronic medical health records, home's internal investigation notes, and staff interviews.

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the resident-staff communication and response system was always easily seen, accessed, and used by the resident.

Rationale and Summary

A CIR was submitted to the Director indicating the resident had experienced an incident and was then sent to a local medical facility for treatment.

As per the resident's electronic plan of care, the call-bell was to be placed within reach as it was a form of fall prevention strategy.

An observation was made where the resident was in their bed but the call-bell was not within their reach. As such, the resident was unable to locate and use the call-bell.

The PSW and the DOC Administration confirmed that the call-bell should always be within reach when the resident was in their bed.

The resident was at risk for falls and having their needs unmet when their call bell was not placed within their reach.

Sources: observations, the resident's care plan, interviews with the PSW and the DOC Administration.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).
The licensee has failed to ensure the implementation of a fall intervention device for the resident.

Rationale and Summary

A CIR was submitted to the Director indicating the resident had experienced an incident and was then sent to a local medical facility for treatment.

As per the resident's electronic plan of care, a fall prevention intervention was to be utilized when the resident was in bed. The intervention was to be checked by the PSW to ensure correct placement and functionality.

An observation was made where the resident was in their bed, but the intervention was on one side of the bed and not connected to the system. A PSW had entered the room and reconnected the intervention for the resident.

The PSW confirmed it was the staff's responsibility to ensure the functionality of the intervention and acknowledged that the intervention was not checked after transferring the resident back to their bed.

The resident was at increased risk for falls when staff did not ensure the fall prevention intervention was functional after placing the resident in bed.

Sources: observations, the resident's care plan, interviews with the PSW and the DOC Administration.

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure proper techniques were used to assist with the resident when eating.

Rationale and Summary

A CIR was submitted to the Director indicating the resident had experienced an incident during a mealtime and was then sent to a local medical facility for further care and treatment.

A review of the resident's electronic health records that they were assessed by a member of the interprofessional team member about a year ago. Multiple safe eating and drinking strategies were made and documented in the resident's plan of care. The strategies were to be followed by the nursing staff up until the resident had experienced the incident. It was also noted in the resident's chart that they could feed themselves during mealtime.

On one day, the resident was observed to be consuming a meal in the communal dining room by themselves, and no staff was seated with the resident. However, a registered staff stated that they were monitoring the resident throughout the mealtime. While a PSW was preparing drinks, the staff had heard the resident tapping and banging on the table. Multiple staff immediately attended to the resident and began performing emergency procedures. The resident was later sent to a local medical facility for additional treatment.

The DOC Administration stated that a staff should have seated with the resident during meal time to ensure the specific safe eating strategy was followed, and confirmed that such strategy was not followed at the time of the incident.

There was a moderate risk and impact to the resident as the nursing was unable to accurately ensure that the specific eating strategy was followed.

Sources: CIR, the resident's electronic and non-electronic medical health records, home's internal investigation notes, and staff interviews.

WRITTEN NOTIFICATION: Orientation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (1) 2.
Orientation
s. 259 (1) For the purposes of paragraph 11 of subsection 82 (2) of the Act, the following are additional areas in which training shall be provided:
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

The licensee has failed to ensure the PSW was provided training on safe and correct use of mechanical lifts.

Rationale and Summary

A CIR was submitted to the Director indicating an agency PSW had incorrectly applied a transfer device on the resident and the staff was subsequently sent home the same morning.

As per the home's internal investigation notes and the PSW, the staff was preparing to transfer the resident using a mechanical lift by applying a transfer device to the resident. Another PSW arrived and discovered the device was wrongly applied. At that time, the resident remained in bed and the transfer had not occurred. Additional

staff were alerted of the situation and the identified PSW was sent home shortly after.

The PSW's human resource file and training records were reviewed. There was no record that the staff had received training on how to apply and remove the identified transfer device.

The DOC Administration indicated that the transfer device was part of the mechanical lift system and the PSW was expected to operate the lift as part of their job duties. Both the PSW and the DOC Administration confirmed that the staff did not receive training on the use of transfer device prior to starting their shift at the long-term care home. The DOC Administration was unable to identify the reasons why such training was not provided to the PSW.

With the identified non-compliance, there could be potential risks of harm to the resident for altered skin integrity and slipping out of the sling during a transfer.

Sources: CIR, the resident's electronic and non-electronic medical health records, home's internal investigation notes, and staff interviews.