

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

Public Report

Report Issue Date: December 17, 2025
Inspection Number: 2025-1310-0008
Inspection Type: Critical Incident Follow up
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): December 9, 11, 12, 15, 16, and 17, 2025.

The inspection occurred offsite on the following date(s): December 10, and 16, 2025,

The following intake(s) were inspected:

- Follow-up intake related to IPAC standard
- Intake related to fall of a resident
- Intake related to improper care of a resident
- Intake related to two outbreaks

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 related to O. Reg. 246/22, s. 102 (2) (b)

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

- Infection Prevention and Control
- Residents' Rights and Choices
- Falls Prevention and Management

INSPECTION RESULTS

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

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 5.

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:

5. Every resident has the right to freedom from neglect by the licensee and staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as means "the failure to provide a resident with the treatment, care, services, or assistance required for their health, safety, or well-being, and includes inaction that jeopardizes the health, safety, or well-being of one or more residents".

The resident reported not feeling well to the homes staff and the home's nursing staff did not address the residents concern in a timely manner. The resident was later treated for an identified diagnosis.

Sources: Critical incident system (CIS) report, residents electronic records, and interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: No clear direction

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The long-term care home did not ensure that the written plan of care for the resident set out clear directions to staff and others who provide direct care to the resident.

The care plan for the resident had identified care which was to be provided to the resident by homes staff which was not provided.

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

Sources: CIS report, residents' electronic documentation, interview with PSW and DOC.

WRITTEN NOTIFICATION: Based on assessment of resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

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 on the needs and preferences of that resident.

The Long-Term Care Home received a complaint from the family of a resident not feeling well. Review of residents' plan of care did not reflect the resident's needs and preferences for activities of daily living (ADL). The care set out in the plan of care was not based on an assessment of the residents and on their needs and preferences.

Sources: Residents clinical records, interview with PT and PSW staff.

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)

Pain management

s. 57 (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.

The Long-Term Care Home received a complaint from the family of the resident who voiced not feeling well which was reported to home staff. A review of the care records revealed that, when resident expressed concern to staff. The resident was not assessed using a clinically appropriate assessment instrument and was later treated for an identified diagnosis.

Sources: Review of residents clinical records, the home's policy and interview with DOC and NP.

WRITTEN NOTIFICATION: IPAC Program

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

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

All staff are to participate in the implementation of the infection prevention and control program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that a written policy was developed for infection control program and was complied with.

An identified home areas was declared in an outbreak
Multiple observations were conducted, it was observed that multiple staff in the home did not follow the home's universal precautions in donning surgical masks during an influenza A outbreak.

Sources: CIS report, observations, home's policy, and interview with IPAC lead.

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

- 1) Review for four weeks of incidents which occur on an identified floor ensuring to investigate in detail cause
of the fall, staff involved, and injuries sustained

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

2) The home is to keep a detailed record of its investigation

Grounds

The long-term care home did not protect a resident ensuring that the resident was not neglected by the licensee or staff.

The resident had an incident, to which the care plan had interventions to ensure the residents' was safe.

Through interviews with the PSW the PSW did not follow the resident's written plan of care and the resident sustained injuries.

Source: CIS report, residents' electronic documentation, interview with PSW and DOC.

This order must be complied with by March 4, 2026

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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

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

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