Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2013	2013_108110_0009	T-153-13	Critical Incident System

Licensee/Titulaire de permis

~~McKenzie Health~~ MacKenzie Health RB

10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3

Long-Term Care Home/Foyer de soins de longue durée

MacKenzie Health
10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DIANE BROWN (110)

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): May 23rd and May 27th, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Dietitian(RD), Food Service Manager, Personal Support Workers, Food Service Workers, Resident

During the course of the inspection, the inspector(s) observed meal service, reviewed resident health record and the home's menu.
This inspection related to Log# T-153-13

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that a written plan of care sets out clear directions to staff and others who provide direct care to residents.
Staff interviews and record review revealed that resident #001's plan of care did not provide clear directions for staff serving meals. Resident #001 choked on a food item and required the Heimlich Manoeuvre with a transfer to hospital. Staff interviews revealed discrepancies in the interpretation of residents #001's diet texture. The Registered Dietitian confirmed that the food texture of the food served was not appropriate for this resident and should not have been served. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

The licensee failed to ensure that planned menu items are offered and available at each meal. On May 23rd, 2013 at lunch, observations, menu review and staff interviews confirmed that all menu items were not served to residents according to the planned menu. Interview with the Food Service Manager confirmed that staff did not follow proper procedures when menu items were not available. [s. 71. (4)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

The licensee failed to ensure that there is an organized food production system in the home and that the food production system include documentation on the production sheet of any menu substitutions.
Observations, record review and staff interview confirm that menu changes observed at lunch on May 23rd, 2013 were not documented on the home's production sheet. [s. 72. (2) (g)]

Issued on this 28th day of June, 2013

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

Dare Brown