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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Apr 17, 2014	2014_168202_0009	T-442-14	Critical Incident System

Licensee/Titulaire de permis

McKenzie Health
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

VALERIE JOHNSTON (202)

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 25, 26, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), registered nursing staff, physiotherapist, personal support workers (PSW), resident.

During the course of the inspection, the inspector(s) observed the provision of care to residents, observed resident #001's room, reviewed clinical records, reviewed the home's policies related to fall prevention and management.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care is provided to the

resident as specified in the plan.

A review of resident #001's plan of care identified the resident as high risk for bleeding related to medication use during hemodialysis treatments, and oral medications used at the home. Resident #001 is assisted by one staff member during transfers and is able to weight bear. The written plan of care for resident #001 directs staff to report all falls, any injury, hitting the head, and any other changes in the resident's status to the hemodialysis unit prior to treatment. Staff indicated that they are directed to fill out the hemodialysis communication tool form in each resident's individualized dialysis record book. The communication tool allows staff of the home to notify the hemodialysis unit of any high risk concerns such as a fall or head injury. On an identified date and time, resident #001 was found on the floor at his/her bedside. PSW #1 indicated that while he/she was in resident #001's room, retrieving an article of clothing, the resident slipped to the floor from a sitting position on his/her bed. PSW #1 indicated that he/she used the call bell for assistance and attempted to transfer resident #001 from the floor to his/her wheelchair. PSW #2 indicated that he/she responded to the call bell immediately and when he/she arrived at resident #001's room, he/she found PSW #1 leaning over resident #001 attempting to hold the resident up at the end of resident #001's bed. PSW #2 indicated that both him/herself and PSW #1, transferred resident #001 to his/her wheelchair and alerted the night RPN. The RPN indicated that he/she entered resident #001's room, found PSW #1 holding a cold compress to an identified area of the resident body in the resident's washroom. The RPN indicated that during his/her assessment there were no visible injuries other than resident #001 complaining of pain in the identified area. The resident indicated to the RPN that he/she hit an identified area of his/her body on the bed side table and that he/she would not do this again because it hurt. PSW #1 then transferred resident #001 from his/her bedroom to the nursing station in order to wait his/her transfer to the hemodialysis unit. An interview with the day shift RN indicated that on an identified date, he/she noted that resident #001 was injured and the resident complained of pain. Approximately 30 minutes after resident #001's fall, he/she was transferred by a porter from the home area to his/her scheduled hemodialysis appointment. Approximately three hours later, the RN received a phone call from the hemodialysis unit, requesting to know if resident #001 had a recent fall. The dialysis RN indicated to the RN that resident #001 required a medication, however, expressed concern as he/she noted that resident #001's had an apparent injury. The RN confirmed to the dialysis staff that resident #001 had injured him/herself earlier that morning, however, only became aware during this phone call that the hemodialysis team had not been informed of resident #001's injury. The RN indicated that communication tool was

completed, however the information within the communication tool neglected to inform the hemodialysis team that resident #001 had a fall or injury. Resident #001 returned to the home after the hemodialysis appointment, was sent to hospital the following day for assessment of increasing lethargy, confusion and restlessness. Resident #001 passed away four days later while at the hospital due to complications of related to the fall. The RPN and the RN confirmed that the care set out in the plan of care for resident #001 was not followed.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's falls prevention policy, #NUR 04-01-53, dated April 01, 2011 is complied with.

The home's falls prevention policy #NUR 04-01-53, dated April 01, 2011, directs staff to initiate a head injury routine for any un-witnessed fall and falls where a resident reports that he/she hit the head during the fall. On an identified date, resident #001 fell and hit his/her head. The head injury routine directs staff to assess resident's vital signs and level of consciousness at directed times, which include every 15 minutes for the first hour, every 30 minutes for the next two hours, every hour for the next four hours, every four hours for the next 16 hours and every eight hours for the next six hours. A review of resident #001's clinical records and staff interviews indicated that resident #001 was not assessed for head injury on all required times as indicated in the policy. The DOC confirmed in an interview that the head injury routine had not been completed for resident #001 in accordance to the home's fall prevention policy. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's falls prevention policy,#NUR 04 -01-53, dated April 01, 2011 is complied with, to be implemented voluntarily.

Issued on this 28th day of April, 2014

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

Valerie Johnston

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2014_168202_0009
Log No. / Registre no:	T-442-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 17, 2014
Licensee / Titulaire de permis :	McKenzie Health 10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3
LTC Home / Foyer de SLD :	MacKenzie Health 10 TRENCH STREET, RICHMOND HILL, ON, L4C-4Z3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL GRIFFIN

To McKenzie Health, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to residents as specified in the plan. The plan should include, but not limited to ensuring appropriate communications are held between the home and the hemodialysis clinic, for residents identified as high risk for bleeding and receive scheduled hemodialysis treatments. Please submit the plan to valerie.johnston@ontario.ca by May 09, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of resident #001's plan of care identified the resident as high risk for bleeding related to medication use during hemodialysis treatments, and oral medications used at the home. Resident #001 is assisted by one staff member during transfers and is able to weight bear. The written plan of care for resident #001 directs staff to report all falls, any injury, hitting the head, and any other changes in the resident's status to the hemodialysis unit prior to treatment. Staff indicated that they are directed to fill out the hemodialysis communication tool form in each resident's individualized dialysis record book. The communication tool allows staff of the home to notify the hemodialysis unit of any high risk concerns such as a fall or head injury. On an identified date and time, resident #001 was found on the floor at his/her bedside. PSW #1 indicated that while he/she was in resident #001's room, retrieving an article of clothing, the resident slipped to the floor from a sitting position on his/her bed. PSW #1 indicated that he/she used the call bell for assistance and attempted to transfer resident #001 from the floor to his/her wheelchair. PSW #2 indicated that he/she responded to the call bell immediately and when he/she arrived at resident #001's room,

he/she found PSW #1 leaning over resident #001 attempting to hold the resident up at the end of resident #001's bed. PSW #2 indicated that both him/herself and PSW #1, transferred resident #001 to his/her wheelchair and alerted the night RPN. The RPN indicated that he/she entered resident #001's room, found PSW #1 holding a cold compress to an identified area of the resident body in the resident's washroom. The RPN indicated that during his/her assessment there were no visible injuries other than resident #001 complaining of pain in the identified area. The resident indicated to the RPN that he/she hit an identified area of his/her body on the bed side table and that he/she would not do this again because it hurt. PSW #1 then transferred resident #001 from his/her bedroom to the nursing station in order to wait his/her transfer to the hemodialysis unit. An interview with the day shift RN indicated that on an identified date, he/she noted that resident #001 was injured and the resident complained of pain. Approximately 30 minutes after resident #001's fall, he/she was transferred by a porter from the home area to his/her scheduled hemodialysis appointment. Approximately three hours later, the RN received a phone call from the hemodialysis unit, requesting to know if resident #001 had a recent fall. The dialysis RN indicated to the RN that resident #001 required a medication, however, expressed concern as he/she noted that resident #001's had an apparent injury. The RN confirmed to the dialysis staff that resident #001 had injured him/herself earlier that morning, however, only became aware during this phone call that the hemodialysis team had not been informed of resident #001's injury. The RN indicated that communication tool was completed, however the information within the communication tool neglected to inform the hemodialysis team that resident #001 had a fall or injury. Resident #001 returned to the home after the hemodialysis appointment, was sent to hospital the following day for assessment of increasing lethargy, confusion and restlessness. Resident #001 passed away four days later while at the hospital due to complications of related to the fall. The RPN and the RN confirmed that the care set out in the plan of care for resident #001 was not followed. (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 20, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Valerie Johnston

Name of Inspector / Nom de l'inspecteur : Valerie Johnston

Service Area Office / Bureau régional de services : Toronto Service Area Office