Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2019	2019_763116_0007	021904-19	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

MacKenzie Place
52 George Street NEWMARKET ON L3Y 4V3

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 26, 27, 28 & December 2, 3, 4, 2019.

The following intake was completed in this inspection:
Log # 021904-19 related to skin and wound care concerning resident #001 was inspected.

During the course of the inspection, the inspector reviewed clinical health records, staffing schedule, and relevant home policies and conducted observations, record reviews and interviews.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Personal Support Workers (PSWs) and substitute decision maker (SDM) of resident #001.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 :

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

A complaint was submitted to the Ministry of Long Term Care (MLTC) related to care issues for resident #001 which resulted in a transfer to the hospital.

Review of the written plan of care related to an identified focus indicated the resident was at high risk for impaired skin integrity and was receiving treatment.

A review of the resident's health record including medication administration records (MAR), treatment administration records (TAR) and progress notes were reviewed for an identified period.

Record review revealed that on an identified date, an external specialist conducted a reassessment for specified areas of altered skin integrity and prescribed a treatment order for resident #001.

Review of progress notes for specified dates, and TAR provided conflicting information. The progress notes indicated that a component of the prescribed treatment was unavailable as the homes pharmacy provider does not carry the product however, the TAR was signed off as given on the identified dates.

Interviews held with registered staff member #'s 102, #103 and #105 indicated they were responsible to monitor skin impairments and were instructed to provide the prescribed treatment. An interview held with RPN #105 who was assigned to the resident on a specified date, indicated that the treatment was provided without a component of the prescribed treatment plan.

During an interview, the DOC stated that ADOC #115 and registered nurses are expected to contact the external specialist and/or pharmacy to obtain an order for alternative treatments when a prescribed treatment plan is not available.

Review of resident #001's health record and interviews held with registered staff found that there was no documentation to support that redirection or an alternative to the treatment order were obtained.

Interviews held with RPN #105, the DOC and the ED confirmed that the care set out in the plan of care related to the required treatment was not provided to resident #001 as specified in the plan on identified dates. [s. 6.(7)] [s. 6. (7)]

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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of December, 2019

[redacted]

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

Original report signed by the inspector.