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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2017	2016_486653_0016	034356-16	Resident Quality Inspection

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 Long Term Care Facility
10 TRENCH STREET RICHMOND HILL ON L4C 4Z3

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

ROMELA VILLASPIR (653), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 14, 15, 16, 19, 20, 21, 22, 23, 2016, and January 3, 4, 5, 6, 2017.

During the course of the inspection, the inspector(s) toured the home, conducted observations of residents and care provided by staff, reviewed residents' health records, staff schedule, and relevant policies and procedures.

The following intake(s) were inspected concurrently with the Resident Quality Inspection (RQI):
Complaint related to prevention of abuse and neglect.
Follow-up on a compliance order related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision Makers (SDMs), President of Residents' Council, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Charge Registered Nurse (CRN), Housekeeper (HK)/ Environmental Associates (EA), Carpet Floor Specialist (CFS), Environmental Services Coordinator (ESC), Director of Environmental Services (DES), Social Worker (SW), Registered Dietitian (RD), Director of Care (s) (DOCs), and the Administrator.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_302600_0024	653

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her 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 his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity

During stage one of the Resident Quality Inspection (RQI), resident #007 indicated that after his/her admission on an identified date, an identified Personal Support Worker

(PSW) pulled the resident by his/her shirt when the resident was sitting in the wheel chair. The resident stated that he/she refused to change his/her shirt and the resident was unsure why the identified PSW wanted to change the resident's shirt. Resident #007 indicated that the identified PSW did not harm him/her but the incident made the resident feel bad. Resident #007 further indicated that he/she did not report the incident as it made him/her scared.

A follow-up interview carried out in stage two of the RQI inspection with resident #007 provided the same information that the resident had provided to the inspector in stage one.

An interview conducted with PSW #127 indicated he/she knew resident #007 and the resident's care needs. The PSW further indicated he/she was not resident #007's primary PSW. PSW #127 was not able to recall the incident and indicated that if there was a reported incident, the home would have contacted PSW #127 to address the incident.

An interview held with PSW #132, resident #007's primary PSW, indicated the resident was competent and able to communicate his/her needs through his/her own means of communication. The PSW further stated to the inspector that resident #007 was quiet when the resident was admitted to the home, although the resident was aware of his/her surroundings. PSW #132 indicated that if resident #007 stated the above incident occurred, then it would have occurred as the resident was competent and knew what was happening around him/her.

An interview with Charge Registered Nurse (CRN) #133 indicated resident #007 was competent and able to make his/her needs known through his/her own means of communication. CRN #133 indicated if the incident did occur, PSW #127 did not respect resident #007's right to not change his/her shirt.

During an interview, the Administrator stated if a resident refused care, staff would have to respect the resident's wishes. The Administrator acknowledged the incident and indicated resident #007 was competent. He/she further indicated that PSW #127 went against the resident's wishes when the PSW tried to change the resident's shirt. The Administrator confirmed that resident #007's right to be treated with respect and dignity had not been fully respected and promoted. [s. 3. (1) 1.]

2. The licensee has failed to fully respect and promote the residents' right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date, on an identified floor, inspectors #604 and #665 noticed from the hallway that resident #025 was in his/her room and resident #025's identified body part was visible from the hall. Inspector #604 noticed that the resident was being provided personal care by two staff members with the resident's room door open and privacy curtain was not fully closed. It was noted that another resident was sitting across the hall from resident #025's room and family members were also passing by the hall. The staff member closed the privacy curtain further when he/she noticed inspector #604 in the hall, outside of resident #025's room.

Interviews conducted with PSW #112 and agency PSW #124 indicated they were with resident #025 in his/her room providing personal care to the resident, and resident #025's privacy curtain was not fully closed and the resident's door was open. PSW #112 identified this incident did not fully respect the resident's right to privacy. The PSWs indicated the home's expectation was to provide privacy during care by closing the privacy curtains and the door. The PSWs confirmed the privacy curtain was not fully closed and resident #025 was not provided privacy during care.

During an interview, the Administrator stated that the home's expectation was for staff to provide care to the residents in a private manner. The staff need to knock on the door, enter the room, inform the resident of the care to be provided, and pull the privacy curtains. The Administrator was informed of the inspector's observations, and the Administrator identified the incident to be a breach of resident #025's privacy. [s. 3. (1) 8.]

3. During stage one of the RQI, resident #003 informed inspectors #604 and #665 that on an identified date, resident #003 was having a shower in the shower room assisted by PSW #102. The resident stated RPN #103 came in the shower room without knocking on the door and resident #003 was disturbed in the shower. RPN #103 indicated he/she was looking for another resident and left the shower room without apologizing to resident #003. The resident indicated the incident made him/her feel bad and upset. He/she also stated that the RPN does this same thing all the time.

An interview with RPN #103 confirmed the incident above occurred, and stated to the inspector that he/she had knocked on the door before entering the shower room. The RPN further stated that he/she apologized to resident #003 for entering the shower room.

An interview with PSW #102 confirmed the above incident did occur and that he/she did

room, the shower could be heard from the hall. PSW #102 identified this incident as not fully respecting resident #003's right to privacy.

During an interview, the Administrator indicated staff were expected to knock on closed doors before entering the room. The Administrator identified this incident as not respecting the resident’s privacy. The Administrator further indicated that resident #003's right to privacy in treatment had not been fully respected and promoted by RPN #103. [s. 3. (1) 8.]

4. The licensee has failed to fully respect and promote the resident’s right to have his or her 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 his or her records of personal health information, including his or her plan of care, in accordance with that Act.

During a stage one interview of the RQI inspection, resident #003 triggered for dignity lacking.

During an interview, resident #003 stated that on an unidentified date, resident #003 was scheduled to receive an identified medication at an identified time. At approximately 1/2 hour (hr) after the identified time, resident #003 was in the hallway across the elevator, about to return to his/her room. Registered Nurse (RN) #125 was in the nursing station, and waved the identified medication to resident #003, while asking if the resident needed it. Resident #003 stated that it made him/her upset as there were other people around when the RN waved the identified medication and asked if the resident needed it.

During an interview, RN #125 confirmed the above-mentioned incident occurred. RN #125 further indicated that he/she did not keep resident #003’s personal health information confidential when RN #125 asked the resident regarding the identified medication in a public area.

During an interview, the Administrator confirmed the above-mentioned incident. The Administrator further indicated that the home’s expectation is for staff to ensure that personal health information is shared with the resident privately. [s. 3. (1) 11. iv.]

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 following rights of residents are fully respected and promoted:
-1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
-8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
-11. Every resident has the right to have his or her 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 his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area that was used exclusively for drugs and drug-related supplies.

During an observation on December 23, 2016, at 1515 hrs, a non-drug related supply was found by RPN #118 and inspector #653 in the narcotic storage bin on the fifth floor.

The following non-drug related supply was found:
-small plastic bag with cash.

During an interview, the Director of Care (DOC) confirmed that the above-mentioned non-drug related supply was found with the narcotic drugs in the narcotic storage bin on the fifth floor. The DOC further indicated that the home's expectation was for drug-related supplies to be the only items stored in the narcotic storage bin. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

On January 5, 2017, at 1515 hrs, on the east wing of an identified floor, inspector #665 observed a clear zip lock bag sitting on top of a cart that was labelled "Dressing Cart". There were three medicated creams found in the zip lock bag.

The three medicated creams were labelled with resident #026's name.

During an interview, RPN #108 confirmed the above findings and stated that creams must be kept inside the locked dressing cart to ensure medications were protected from passersby. [s. 129. (1) (a)]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.