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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_486653_0017	031984-16, 032432-16, 032856-16, 000999-17, 004882-17, 008300-17	Complaint

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)

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): August 18, 21, 22, 23, 24, 25, 28, 29, and 30, 2017.

The following intakes were inspected concurrently during this inspection:
Log #(s): 031984-16, 032432-16, 032856-16, 000999-17, 004882-17, and 008300-17.

During the course of the inspection, the inspector conducted a tour of the resident home area, observed staff to resident interactions and provision of care, reviewed clinical health records, staff training records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the resident, Substitute Decision-Maker (SDM), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), RAI-Coordinator, Food Services Attendant (FSA), Environmental Associate (EA), Plant Operations, Security & Fire Prevention Officer, and the Administrative Director of Care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. (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 :

1. The licensee has failed to ensure that the written plan of care set out the planned care for the resident as it related to responsive behaviours.

The Ministry of Health and Long-Term Care (MOHLTC) received several complaints regarding the care being provided to resident #001.

During an interview, the complainant mentioned to the inspector that he/ she was concerned about resident #003's identified behaviours. He/ she further indicated that there had not been any incidents between residents #001 and #003.

Review of resident #003's health records revealed he/ she had been diagnosed with an identified medical condition. Review of an identified assessment on two identified dates, revealed he/ she exhibited identified behavioural symptoms during the seven day look back period.

Interviews with Personal Support Worker (PSW) #156 and Registered Practical Nurse (RPN) #110 revealed that resident #003 had always exhibited these identified behavioural symptoms. Both staff identified these as resident #003's responsive behaviours. The PSW and RPN further indicated that they perform identified interventions when the resident is exhibiting responsive behaviours.

Review of resident #003's written plan of care on an identified date, did not identify the identified responsive behaviours and the strategies/ interventions that the staff have implemented to manage the resident's behaviours.

Interviews with RAI-Coordinator #137 and RPN #110 confirmed that resident #003's written plan of care did not include his/ her identified responsive behaviours, and the strategies and interventions that staff have implemented to respond to the resident's responsive behaviours. Both staff acknowledged that the written plan of care did not set out the planned care for the resident as it related to responsive behaviours.

Interview with the Administrative Director Of Care (ADOC) acknowledged that the resident's written plan of care did not set out the planned care for the resident in regards to his/ her identified responsive behaviours, and the strategies/ interventions implemented by the staff to manage his/ her responsive behaviours. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

During an interview, the complainant mentioned to the inspector that during a specified activity, resident #002 exhibits an identified behaviour, which prevents resident #001 and the other residents to enjoy the activity.

Review of resident #002’s written plan of care on an identified date, revealed he/ she exhibits responsive behaviours. The written plan of care directs staff to carry out an identified intervention when the resident's behaviour is disruptive/ unacceptable. It had also been indicated in the written plan of care, that staff should always keep the resident in his/ her room due to behaviour and staff to presently engage in the activity in the room as per the family member's request. Review of progress note on an identified date, indicated that the family member requested for the resident to engage in the activity with the other residents.

During an observation on August 25, 2017, resident #002 was engaged in the activity. The resident was observed exhibiting an identified responsive behaviour intermittently, but was not disruptive. The other residents continued engaging in the activity, and did not raise any concerns.

Interviews with PSW #156 and RN #157 stated that they have been engaging the resident with the other residents, but when the resident's identified responsive behaviour starts to become disruptive, they take him/ her back to his/ her room and complete the activity there. RN #157 further acknowledged that resident #002’s written plan of care did not provide clear directions.

Interview with the ADOC acknowledged that resident #002’s written plan of care did not provide clear directions as to where staff were supposed to engage the resident in the specified activity. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out:
-the planned care for the resident;
-clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions, had been documented.

The following were the complainant's concerns:
-Staff had not been providing an identified care intervention to the resident regularly.
-Staff had not been performing an identified care to the resident.

Review of resident #001's written plan of care on an identified date, and interview with RPN #110 revealed he/ she was under an identified required program.

Interviews with PSW #156 and RPN #110 confirmed that the resident had an identified medical condition. PSWs #115 and #156 stated that they perform an identified intervention every two hours in regards to the resident's identified medical condition.

Interview with RAI-Coordinator #137 confirmed that the identified intervention was not written in the plan of care and that the intervention and resident's responses to the intervention should have been documented in the plan of care.

Interview with the ADOC acknowledged that resident #001 was under the identified required program, and the identified intervention should have been on Point of Care (POC) as a PSW task in order for the PSW to document the resident's response to the intervention and the intervention should have also been written on his/ her written plan of care. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that continence care products had not been used as an alternative to providing assistance to toilet.

Interview with resident #001's family member stated that staff members had not been performing an identified care to the resident, and that he/ she witnessed the staff letting the resident perform an identified Activity of Daily Living (ADL) in bed.

Record review of progress note on an identified date, revealed that Physiotherapist (PT) #150 had assessed the resident as per the SDM's request. As discussed with the SDM and the two PSWs after the assessment, it was unsafe for the resident to use the identified equipment to perform an identified ADL. The PT advised the staff to put the resident in bed when the identified ADL was needed to be done.

Record review of resident #001's written plan of care on an identified date, indicated he/ she had an identified medical condition. As discussed and agreed with the SDM, the identified ADL was no longer required to be done using an identified equipment. The written plan of care directed staff to perform an alternative intervention related to the identified ADL.

Interview with PT #150 stated he/ she assessed the resident and deemed it was unsafe for him/ her to perform the identified ADL using the identified equipment.

Interviews with PSWs #115 and #156 stated that due to safety reasons, they have not been using the identified equipment to perform the resident's identified ADL. However, PSW #115 stated that there had been times when resident #001 asked to carry out the identified ADL, and staff transferred him/ her from his/ her identified mobility aid to the bed to perform the identified activity.

Interviews with RPN #110 and the ADOC stated that staff should have used the alternative equipment, or at least offered it to the resident if he/ she asked to carry out the identified ADL. [s. 51. (2) (e)]

Issued on this 12th day of September, 2017

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

Original report signed by the inspector.