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 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
Mar 25, 2019	2019_626501_0004	020813-17, 024663-17, 006693-18, 011228-18, 032225-18, 032226-18, 032227-18	Complaint

Licensee/Titulaire de permis

Mackenzie 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

SUSAN SEMEREDY (501), AMANDEEP BHELA (746)

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): February 7, 8, 11, 13, 14, 15, 19, 20, 21, 22, 25, and 26, 2019.

During the course of this inspection the following complaint intakes were inspected:
#020813-17 related to infection prevention and control, Residents' Bill of Rights,and

the prevention of abuse and neglect.
#024663-17 related to sufficient staffing, bed rails and improper care.
#011228-18 related to skin care.

The following Critical Incident System (CIS) intake was inspected:
006693-18 related to staff to resident physical abuse.

The following follow up intakes were inspected:
#032225-18 related to ensuring staff comply with the licensee's policy that promotes zero tolerance of abuse and neglect.
#032226-18 related to ensuring the licensee's policy that promotes zero tolerance of abuse and neglect meets all legislative requirements.
#032227-18 related to ensuring the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident immediately reports the suspicion to the Director.

Written Notification and Voluntary Plan of Correction related to LTCHA,2007, S.O. 2007, C.8, s. 6(5), identified in concurrent inspection #2019_594746_0005 related to intake log #022811-17 will be issued in this report.

Written Notification related to O.Reg. 79/10, s. 30 (2), identified in concurrent inspection #2019_626501_0005 related to intake log #005886-18 and #030467-18 will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (Clinical)/NP (DOC(C)/NP), registered nurses (RN), registered practical nurses (RPN), social worker (SW), physician, private care giver, personal support workers (PSW), family members, substitute decision-makers (SDM) and residents.

During the course of this inspection the inspector (s) observed staff to resident interactions, the provision of care, and medication administration and reviewed health records, staff training records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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. 20. (1)	CO #001	2018_643111_0018	746
LTCHA, 2007 S.O. 2007, c.8 s. 20. (2)	CO #002	2018_643111_0018	746
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2018_643111_0018	746

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A review of intake #011228-18 indicated resident #003's family member called the Ministry of Health and Long-Term Care (MOHLTC) concerned that the resident had altered skin integrity. According to the intake, the family member observed care being provided on an identified date and could see that the resident had altered skin integrity. The family member was even more concerned because they learned that the staff had been aware of this altered skin integrity previously and no one had contacted them.

A record review of resident #003's medical record revealed the resident was at risk for skin impairment. According to the progress notes and skin assessments, the resident had been identified with altered skin integrity on an identified part of the body on an identified date. During an interview, RN #111 recalled having had assessed this altered skin integrity and getting an order for a treatment. A review of the treatment administration record confirmed a treatment was started on the same day. The progress note did not include any mention of having informed the family. During an interview RN #111 stated they usually inform the family of new altered skin integrity but it is possible that they either forgot to inform them or failed to document that they were informed.

A review of skin assessments indicated the above mentioned altered skin integrity was assessed weekly during an identified time period. There was no indication that it had healed but was no longer being assessed after an identified date.

A review of the progress notes indicated that a few months later, RN #112 wrote that a PSW reported that resident #003 had an identified altered skin integrity which was not new. There was no indication that the family was informed. A further progress note indicated that on an identified date, while providing care for resident #003, a family member noticed altered skin integrity and noted that staff had previously documented it a few days later.

During interviews with RN #109, RN #111 and DOC (C)/NP they indicated that the home had recently changed their protocols to include completing a risk management report for all new altered skin integrity that prompts the staff to inform the family and other appropriate team members. The DOC (C)/NP stated this new protocol was implemented during an identified time period which would have been after the first indication of the

above mentioned altered skin integrity for resident #003.

DOC (C)/NP acknowledged that the registered staff should have informed the family of resident #003's altered skin integrity when it was first noted, when it was healed and when it was again considered altered skin integrity that needed further treatment.

As a result of the above, the designate of the resident/SDM was not given an opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

2. The following finding was found in concurrent complaint inspection report 2019_594746_0005:

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to the care of resident #004.

A telephone interview with the complainant, indicated that the home did not inform or consult with the family prior to and after changing a process in an identified provision of care for resident #004. The family was notified by the private care givers of the change. The complainant indicated that prior to the change, resident #004 successfully received care with occasional unsuccessful attempts. Upon changing the process, the home was frequently unsuccessful which resulted in a decline in the resident's health status.

The complainant further indicated that there were challenges with providing care to the resident due to the resident's cognitive decline. Private care givers were responsible for an identified provision of care if the staff were unsuccessful. The change which took place was such that if the provision of care was made by private care givers, they must be witnessed by the registered staff and further attempts would have to occur within the shift. The complainant indicated they did not have an opportunity to discuss the matter with the home so the family requested a meeting with the home to discuss the changes.

A review of resident #004's electronic progress notes for an identified period of time, revealed there was no indication that a change in process related to an identified provision of care was implemented nor was the family informed of such a change. The notes indicated that a care conference was held on an identified date, to discuss the change and the updated plan of care. In attendance were the family, DOC (Administrative), Administrator, Physician #116 and Registered Nurse (RN) #118.

An interview with RN #118 indicated that no discussion was held with the SDM regarding

the change until a care conference was requested by the family. RN #118 indicated the private care givers informed the SDM two to three days after the change.

An interview with resident #004's private caregiver #119, indicated that they and the other private caregivers informed the SDM about the above mentioned change. Private caregiver #119 indicated that the SDM was shocked and informed the private care givers that they would inquire with the home regarding the changes as they were unaware.

The previous Administrator and DOC (Administrative) were unavailable to be interviewed during the course of the inspection. An interview with DOC (Clinical)/NP #110 acknowledged it was possible the home may not have informed the family of the changes and was unable to provide any evidence that the SDM was given an opportunity to participate fully in the change in an identified provision of care for resident #004. [s. 6. (5)]

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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, 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 following finding was found in concurrent complaint inspection report 2019_626501_0005:

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 were documented.

During an interview with resident #001's family member related to intake #030467-18, they stated that the resident's plan of care was not followed on two identified dates.

A review of resident #001's medical record indicated they were at risk under an identified program. A review of the medication administration record (MAR) for the identified dates indicated that the resident was to receive an identified intervention. The MAR had documentation for only one part of the intervention.

Interviews were conducted with RPNs who worked the above noted dates. Neither RPN could recall failing to deliver the plan of care but acknowledged there was no prompt in the MAR to document the second half of the intervention.

A review of the MAR after speaking with the above staff members, indicated the MAR had been revised to include both the first and second part of the intervention. RN #111, RPN #114 and #120 acknowledged that the second half of the intervention should have been documented.

During an interview with DOC (C)/NP, they acknowledged the second half of the intervention for resident #001 should have been documented. [s. 30. (2)]

Issued on this 26th day of March, 2019

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

Original report signed by the inspector.