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
Jul 9, 2019	2019_563670_0020	013439-18, 017570-18, 018544-18, 019142-18, 027454-18, 030293-18, 000806-19, 000832-19	Critical Incident System

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

DEBRA CHURCHER (670), AYESHA SARATHY (741), CASSANDRA ALEKSIC (689), CHRISTINA LEGOUFFE (730)

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): July 2, 3, 4 and 5, 2019.

The following Critical Incident System inspections were completed;

Log# 000806-19 CIS# 2825-000004-19 related to a fall with injury.
Log# 019142-18 CIS# 2825-000020-18 related to potential improper care resulting in an injury.
Log# 027454-18 CIS# 2825-000029-18 related to a fall with injury.
Log# 030293-18 CIS# 2825-000031-18 related to potential improper care resulting in an injury.
Log# 017570-18 CIS# 2825-000019-18 related to missing controlled substances.
Log# 013439-18 CIS# 2825-000013-18 related to a fall with injury.
Log# 000832-19 CIS# 2825-000005-19 related to an injury of unknown cause.
Log# 018544-18 CIS# 2825-000021-18 related to potential improper care resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Nurse Practitioner/Clinical Director of Care, one Physical Therapist, six Registered Nurses, three Registered Practical Nurses and five Personal Support Workers.

The Inspector(s) also observed staff to resident interactions, observed the provision of care, observed the overall maintenance and cleanliness of the facility, observed a medication pass, observed medication rooms, reviewed relevant resident clinical records for identified residents, reviewed relevant internal investigative notes and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services

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 resident #003 and #004 as specified in the plan.

A) The home submitted Critical Incident to the Ministry of Long-Term Care (MOLTC), related to an incident involving resident #003. The CI stated that resident #003 was receiving interventions from a staff member when the incident occurred that resulted in an injury.

Progress notes were reviewed on Point Click Care (PCC) and indicated that a Personal Support Worker (PSW) was providing specific interventions for resident #003, alone.

The CI stated that resident #003 had been assessed at high risk for a specific condition and that the plan of care indicated that they were a two person constant guidance and physical assistance during a specific intervention. A review of the resident's Physiotherapy assessment prior to the incident also indicated that resident #003 required two person assist for the specific intervention.

During an interview, Personal Support Worker (PSW) #114 was asked about the incident, and said that they were aware the resident's 2 person status for the specific intervention but the resident was able to participate effectively, therefore, they attempted to complete the intervention alone. Registered Nurse (RN) #113 also said that the incident involving resident #003 was a result of having one PSW provide care instead of two PSW's as indicated in the resident's plan of care. In an interview with the Director of Care (DOC) #101, they stated that the resident was a two person assist for the specific intervention, according to their plan of care but PSW #114 attempted the intervention alone. They said the home's expectation was that staff follow residents' plan of care and acknowledged that PSW #114 failed to provide care for resident #003 as specified in their plan.

B) The home submitted Critical Incident (CI) #2825-000021-18 to the Ministry of Long-Term Care (MOLTC), related to the improper treatment of resident#004 by a staff member that resulted in an injury to the resident. The CI stated that resident #004 was received a specific intervention, assisted by one staff member without using the required medical equipment as indicated in the plan of care. As a result, the resident sustained an injury.

The incident note was reviewed in the progress notes section on Point Click Care (PCC), and indicated that resident #004 told staff that Personal Support Worker (PSW) #116 completed the specific intervention alone and without using the required medical equipment.

Resident #004 's Minimum Data Set (MDS) Quarterly Assessment prior to the incident was reviewed on PCC, and stated that the resident required total dependence of two staff for the specific intervention. The Physiotherapy Assessment and Plan of Care prior to the incident were also reviewed and both indicated that resident #004 required the two staff and the use of specific medical equipment to complete the specific intervention.

During an interview, Registered Nurse (RN) #112 said that they documented the incident note and spoke to the resident after the incident happened. They said that the correct process is that staff must follow the Physiotherapist's order for transfers. The Director of Care (DOC) #101 was also interviewed, and they acknowledged that PSW #116 provided care to resident #004 incorrectly according to their plan of care, and said that it is the home's expectation that staff always follow the home's policy, order from Physiotherapy and Plan of Care.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 and resident #004 as specified in the plan. [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 is provided to the residents' as specified in the plan, to be implemented voluntarily.

Issued on this 9th day of July, 2019

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

Original report signed by the inspector.