Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: December 6, 2023	
Inspection Number: 2023-1310-0003	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Mackenzie Health	
Long Term Care Home and City: Mackenzie Health Long Term Care Facility, Richmond Hill	
Lead Inspector Miko Hawken (724)	**Inspector Digital Signature**
Additional Inspector(s) Fatemeh Heydarimoghari (742649)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8 - 10, 14 - 16, 20 - 22, 2023

The following intake(s) were inspected:

- Three intakes related to injury of an unknown cause
- Two intakes related to falls
- Two intakes related to alleged resident to resident abuse
- Intake to follow-up with Compliance Order (CO) #001 / 2023-1310-0002 (A2), O. Reg. 79/10, s. 13, Compliance Due Date (CDD): October 31, 2023
- Two intakes related to alleged staff to resident abuse

- An intake related to COVID-19 outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1310-0002 related to O. Reg. 246/22, s. 13 inspected by Miko Hawken (724)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
Integration of assessments, care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee failed to ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding an unknown cause of an injury for a resident.

The resident's electronic documentation indicated they complained of pain to an extremity which required a specific test, and the result was to be followed up.

The resident's documentation indicated that the home did not follow up on the test result which showed an injury.

The Long Term Care Home (LTCH)'s internal investigation notes indicated a failure of registered staff to write in the 24-hour report book to follow up with the test results which resulted in late diagnosis and treatment.

The Nurse Practitioner (NP) and Registered Nurse (RN) confirmed that the resident did not receive treatment and assessment for several days when the resident had an injury.

Failure to ensure that staff involved in different aspects of care, collaborate with each other, resulted in the delay of the resident receiving treatment.

Sources: CIR, Resident plan of care, the home's investigation notes, and interviews with staff.
[742649]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to ensure that Routine Precautions and Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes (LTCH) issued by the Director, revised September 2023.

Rationale and Summary

In accordance with the IPAC Standards for LTCHs, section 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include, F) Additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal, and disposal.

Specifically, the licensee did not ensure that a Personal Support Worker (PSW) applied the appropriate PPE, while providing personal caring for a resident, who was on additional precautions.

A PSW was observed in a resident's room providing personal care. It was observed that resident required additional precautions. Upon exiting the resident's room, it was observed that the PSW was not wearing the required PPE and disposed of soiled linen outside of the resident's room.

PSW confirmed they did not don the required PPE when providing personal care to the resident. The RN confirmed it was the expectation for all staff to don the appropriate PPE for additional precautions, when providing care to a resident.

Failure to don the required PPE for a resident on additional precautions increased the risk of transmission of infectious disease.

Sources: Observations, interviews with PSW and RN.
[724]

2) The licensee has failed to ensure that Routine Precautions and Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Home (LTCH) 's issued by the Director, revised September 2023.

Rationale and Summary

In accordance with the IPAC Standards for LTCHs revised September 2023, section 6.1 directs the licensee to have PPE available and accessible to staff and residents, appropriate to their role and level of risk.

Specifically, the licensee did not ensure that Personal Support Worker had access to the appropriate PPE, while providing care for a resident, who was on additional precautions.

The LTCH was on a COVID-19 outbreak, a PSW was observed entering a resident's room donning a surgical mask, face shield, and a gown. There was no available N95 masks in the PPE hanger on the door.

The PSW and RN confirmed that an N95 mask was required for a resident who was on additional precautions. They also confirmed that there were no N95 masks available that morning to staff, so staff provided care without the use of N95 masks for the resident that was on additional precautions.

Failure to don an N95 mask increased the risk of the transmission of infectious disease to residents and staff.

Sources: Observations, interviews with PSW and RN.
[724]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act, of a COVID-19 outbreak.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to the outbreak of an infectious disease at the LTCH.

The outbreak was declared by public health one day prior.

The DOC confirmed they had submitted the CIR late by one day.

There was no risk to residents related to the outbreak.

Sources: CIR, and interview with DOC.
[724]

COMPLIANCE ORDER CO #001 Safe and Secure Home

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 13
Elevators
s. 13. Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

- A weekly audit for two months for the administrator or designate to check that the elevators are in working order to ensure that residents do not have access to the ground floor exit to the home. To make notations of any findings or changes and what was done to rectify the changes.
- The administrator or designate to develop and implement a process for communication between the licensee and the Mackenzie Hospital to ensure that the security system of the elevators is functional and working, and it addresses any changes to the security system of the elevators that the hospital makes, is communicated to the licensee appropriately. An agreement and acknowledgement between the licensee and Mackenzie Health should be presented to the inspectors upon entry.

Grounds

The licensee has failed to ensure that any elevators in the home were equipped to restrict resident access to areas that are not to be accessed by residents.

Rationale and Summary

The LTCH is located on the third, fourth and fifth floors of building A, which is shared with the hospital. The home has three elevators, including a service elevator. The service elevator (1) was out of service and inaccessible to general staff, visitors, and residents and only to contractors working on renovations in the building.

Observations showed that the residents, staff, and visitors had restricted access to elevators two (2) and three (3) and required either a card key pass or enter a floor specific elevator code to access floors two to four. On the first floor or ground floor of the building was where the building's exit was located.

Observations also found that access to the ground floor, of both elevators 2 and 3 were accessible to staff, visitors, residents by pushing the ground floor button from any floor and did not require a card key pass or the specific floor elevator code to access the ground floor.

The Administrator acknowledged that residents from each floor could access the ground floor and elope.

It was confirmed via an email from Mackenzie Health Hospital that the elevator service vendor had turned off the security system that limited ground floor access on November 3, 2023, and did not inform Mackenzie Health Hospital or the LTCH of these changes. It was switched back on November 15, 2023, after inspector #724 identified the concern to the LTCH.

In failing to adequately secure the elevators, residents were at a risk of elopement.

Sources: Observations of elevators, Email from Mackenzie Health Hospital, interviews with Administrator.
[724]

This order must be complied with by

March 15, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.