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
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Original Public Report

Report Issue Date: June 04, 2024	
Inspection Number: 2024-1310-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Mackenzie Health	
Long Term Care Home and City: Mackenzie Health Long Term Care Facility, Richmond Hill	
Lead Inspector Fatemeh Heydarimoghari (742649)	**Inspector Digital Signature**
Additional Inspector(s) Natalie Jubian (000744)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6 to 10, 2024

The following intake(s) were inspected:

The following intake(s) were completed in this complaint inspection:

- One intake related to the fall of the resident
- One intake related to food, staffing, housekeeping, pest control and staffing.
- One intake related visitation and medication administration.

The following intakes were completed in this Critical Incident (CI) inspection:

- Two intakes were related to visitor to resident abuse
- One intake related to the neglect of the resident
- One intake related to the fall of the resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 6.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
6. Every resident has the right to communicate in confidence, receive visitors of their choice and consult in private with any person without interference.

The licensee failed to ensure resident #003's right to communicate, in confidence, to receive visitors of their choice without interference was fully respected and promoted.

Rationale and Summary

A complaint was received by the Director regarding resident #003's substitute decision maker (SDM) being banned from the home. Resident #003 had been emotionally dependant on their SDM, however the home banned them from visiting.

Resident #003's clinical records indicated that the resident's SDM, and other family members, were not permitted to visit the resident. Additional critical incident reports related to the same incident were submitted to the Director with concerns about the suspected abuse of resident #003 by their SDM. The resident indicated to the Social Worker and Associate Director of Care (ADOC) that they had no concerns related to their safety and would like to continue visitation from their SDM.

The Social Worker and Administrator acknowledged that the home did not consider the resident's wishes to see their SDM and other family members when they were banned.

By failing to consider resident #003's wishes to see their family, there was a potential risk to the resident's emotional and physical well-being.

Sources: Resident #003's clinical records and interview with Administrator and Social Worker. [742649]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

The licensee failed to ensure that resident #003's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of their plan of care.

Rationale and Summary

The Director received a complaint regarding resident #003's substitute decision maker (SDM) being banned from the home. Resident #003's SDM was alleged to have threatened to not follow the resident's medication order because they felt the home was not following the specialist recommendations for the medication.

Resident #003's clinical records indicated the home did not feel the specialist recommendations were safe for the resident, regardless of resident #003's SDM's wishes to follow them. The specialist recommendation was provided twice, however, resident #003's SDM was not updated regarding the change.

Registered Nurse (RN) and the Administrator acknowledged that the home did not inform resident #003's SDM regarding the changes.

Failure to communicate the medication dosage change with resident #003's SDM placed the resident at moderate risk of harm.

Sources: Resident's clinical records, interviews with RN and Administrator. [742649]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE- LICENSEE

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

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward to the Director any written complaint that it receives concerning the care of a resident where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary

A CIR (Critical Incident Report) was submitted to the Director related to a written complaint made by resident #004's Substitute Decision Maker (SDM) on a specified date. The written complaint was sent to the home's Administrator through electronic mail (e-mail).

The complaint was related to the care resident #004 received regarding a wound. The complaint alleged the resident's wound dressing had not been changed as per the order resulting in infection. The complaint was not forwarded to the Director until three days after.

The Administrator acknowledged the complaint was received through writing and was concerning the care of a resident.

Failing to immediately forward the complaint to the Director posed no risk to the resident.

Sources: CIR and interview with Administrator. [000744]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that an alleged abuse incident of resident #003 was immediately investigated.

Rationale and Summary

A complaint and CIR was submitted to the Director regarding an alleged visitor to resident abuse incident wherein resident #003's SDM refused to send the resident to hospital, despite the resident requesting to be sent.

Resident #003 had requested to be sent to the hospital as they were not feeling well. The resident's SDM was notified and they had insisted for resident #003 not to be sent to the hospital, despite them feeling unwell. The home indicated resident #003 appears cognitively well enough to make their own decisions, despite their SDM mentioning they cannot. The home was unable to provide investigation notes regarding the alleged abuse incident.

The Administrator acknowledged the home did not conduct a formal investigation into the incident.

There was a potential risk to resident safety and further incident of abuse toward resident #003 when the home failed to investigate the incident.

Sources: CIR, resident’s clinical records, and interview with Administrator. [742649]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report abuse or neglect of resident #003 that may have resulted in harm, or risk of harm, to the resident.

Rationale and Summary

A complaint and Critical Incident Report (CIR) was submitted to the Director regarding an alleged visitor to resident abuse incident wherein resident #003's SDM refused to send the resident to hospital, despite the resident requesting to be sent.

The CIR indicated the alleged abuse incident occurred on a specified date, however was not reported to the Director until six days later. The Administrator confirmed that the Physician notified the home of their suspicion of alleged abuse toward resident #003 on a specified date, however the home did not report the suspicion until six days later.

There was a low risk to the resident when a home failed to report to the Director immediately.

Sources: CIR and interview with Administrator. [742649]

WRITTEN NOTIFICATION: FOOD PRODUCTION

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production

s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee failed to ensure that all food and fluids in the production system were served using methods to prevent adulteration, contamination and food borne illness.

Rationale and Summary

During a dining observation, prior to meal service, a tray of regular and pureed fruit were noted on the outside of the servery uncovered. No dietary aides were present in the servery.

A resident was noted in front of the servery, waiting for the dietary staff to arrive. A family member walked into the dining room, was greeted by the resident, and they both stood in front of the servery, over the tray of fruit. The resident and family member proceeded to grab bowls of fruit off the tray, looked at it and put it back onto the tray. The resident then took a napkin from on top of the servery and blew their nose over the opened tray of fruit. Two dietary aides walked into the servery and started to prepare slices of cake for lunch service. The inspector asked the dietary aides if it was common practice to leave a tray of fruit uncovered on the opposite side of the servery, to which the dietary aide responded no and was unsure of how long the tray of fruit had been left out.

Once the cake slices were prepared, the dietary aide came to the opposite side of the servery and covered the fruit tray and cake slices with plastic wrap and left the trays on a table beside the servery. No temperature was noted to have been taken of the fruit prior to or during the dining service.

The Food Service Manager (FSM) indicated fruit and dessert are to be stored in the fridge in the servery until near the end of the service, to ensure they were at the

correct temperature. They further confirmed the fruit was not stored in a way to prevent adulteration, contamination, and food borne illness.

Failing to ensure the fruit was stored appropriately put the residents at risk of illness.

Sources: Observations, interview with FSM. [000744]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure that the correct seven day menu was posted in all dining rooms.

Rationale and Summary

During the inspection, the Fall/Winter Menu-Week two (November 13 to May 5, 2024) were observed to be posted on the bulletin boards in all dining rooms in the home. The daily menus posted outside of the dining rooms indicated the Fall/Winter Menu for Week three and coincided with the food being served that day.

The Food Services Manager confirmed that the weekly menus displayed were out of cycle and should have been updated to reflect the Fall/Winter Menu-Week three cycle.

Failure to communicate the correct weekly menu to residents may decrease the resident's enjoyment of the meal service.

Sources: Observations, interview with staff. [000744]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee failed to ensure they kept a documented record of verbal complaints regarding resident #003's care.

Rationale and Summary

A complaint was submitted to the Director regarding resident #003's medication, as the home did not follow the recommendation from resident #003's specialist. Resident #003's SDM disagreed with the home's decision to not follow the specialist 's recommendation and brought this forward as a complaint to the home on multiple occasions.

Resident #003 's clinical records identified their SDM had made complaints multiple times regarding the resident's medication to the Social Worker and to an RN at a

care conference. The Social Worker and RN confirmed the same, however no formal process was followed to resolve the SDM's concerns.

A review of the home's complaints binder supported there was no documented record kept in the home of the nature of the complaint, the date the complaint was received, the follow up action to resolve the complaint, the final resolution, every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the SDM.

The Administrator confirmed that the home has a policy regarding verbal or written complaints and will investigate and try to resolve them within 24 hours. Regarding a verbal complaint, there's a complaint form. Usually, whoever is involved in the complaints add their notes to the complaint form, and then there is a tracking sheet for complaints to follow up.

There was a moderate risk to the resident's health when a home did not follow up on SDM's concern.

Sources: Progress notes, the home's complaints policy, and interviews with staff. [742649]