Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: March 13, 2024	
Inspection Number: 2024-1121-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: MacKenzie Place, Newmarket	
Lead Inspector Asal Fouladgar (751)	**Inspector Digital Signature** Asal Fouladgar Digitally signed by Asal Fouladgar Date: 2024.03.28 14:29:26 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27-29, 2024, and March 4-6, 2024.

The following intake(s) were inspected:

- An intake related to a disease outbreak.
- An intake related to fall resulting in significant change in status.

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

Medication Management
Infection Prevention and Control
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

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 has failed to ensure that staff involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident so their assessments were integrated and consistent and complemented each other.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to fall of resident #001 resulted in significant injury. Upon an observation during this inspection, the resident was transferred via a mechanical lift by two staff. The resident's care plan and the transfer sign in the resident's room indicated a different method of transfer.

Personal Support Worker (PSW) # 115 stated that they used the mechanical lift at times when the resident was unstable on their feet and that they had already spoken to the home's Physiotherapist (PT), however they had not informed the registered staff about the same.

The PT confirmed the above and stated they did not communicate such with any other nursing team member. Registered Nurse (RN) #119 and Registered Practical

Nurse (RPN) #118 indicated that they were not aware the resident required a mechanical lift at times hence the resident's care plan was not updated accordingly.

When registered staff were not aware that a mechanical lift was being used to transfer the resident at times, the required assessments, referrals, monitoring, and care plan updates were not consistently done to ensure that all staff who provided care to the resident were aware of the resident's care need.

Sources: Observations, resident #001's clinical records, and interviews with staff. [751]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident #001's plan of care was revised when the resident's care needs changed related to their risk of fall and safety.

Rationale and Summary

A CIR was submitted to the Director related to fall of resident #001 resulted in significant injury. The resident's written care plan prior to their recent fall did not include the use of a specific mobility device and an equipment.

A documentation by the PT a couple of weeks prior to the resident's recent fall, indicated that the resident could use that specific mobility device on specified days for safety, however the resident's care plan was not revised to include this information.

Another documentation by RN #119 a couple of months prior to the resident's recent fall, indicated that the resident required a special equipment for their safety. This was not reflected in the resident's care plan.

The Director of Care (DOC) acknowledged that the resident's care plan must have been revised to include such information.

The resident was at risk of injury when the care plan was not updated to include the resident's occasional need to use the mobility device as it also led to lack of further assessment by the nursing team for the need of special equipment to be in place on that mobility device due to the resident's fall risk.

Sources: Resident #001's clinical records, the CIR related to the resident's fall, and interviews with staff.
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WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee has failed to ensure that the written description of the home's falls prevention program included procedures and protocols related to the use of bed and chair alarms as a method of reducing risks of falls for residents.

Rationale and Summary

The home's falls prevention policies, protocols, and worksheets indicated no information on how and when to use bed or chair alarms for the residents who were at risk for falls.

Multiple staff interviews indicated that bed and chair alarms were available and being used in the home as an equipment to reduce the risk of falls. The DOC indicated that the home did not have a policy specific to the use of bed and chair alarms, however they were being used as an additional intervention for the residents who may require additional support beyond the home's universal fall precautions.

There was a risk to the safety of the residents when staff did not have clear direction on how and when to use bed or chair alarms for residents at high risk of falls when the home's policies or protocols did not include such information.

Sources: The home's policy titled "Resident Safety", Fall Prevention and Injury Reduction Workflow, and interviews with staff.
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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce

transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were recorded.

Rationale and Summary

A CIR was submitted to the Director related to a disease outbreak in the home. Residents #003 and #004 were identified to have symptoms of infections during a specific time of the outbreak.

The home's policy on reporting infection indicated that the unit nurse/designate were required to document the signs and symptoms of the residents' infection in the electronic health record each shift until resolved.

The residents' electronic progress notes did not include consistent documentations of their infection status on several shifts and days within the outbreak period.

The DOC acknowledged that the staff were required to document the symptoms of the residents on every shift until they were recovered.

The lack of documentation during the specified period might have affected the interprofessional team's understanding of residents' #003 and #004 health condition.

Sources: The CIR related to the home's disease outbreak, the home's line-list related to the outbreak, residents' #003 and #004 clinical records, the home's policy titled "Infection Surveillance and Disease Reporting", and interview with the DOC.
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WRITTEN NOTIFICATION: Safe storage of drugs

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

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee has failed to ensure that multiple prescribed topical medications for residents #001, #004, and #005 were stored in an area which was used exclusively for drugs and drug-related supplies.

Rationale and Summary

Upon an observation during this inspection, Inspector #751 observed three bags of prescribed medications for residents #001, #004, and #005 inside a resident's room.

RN #119 and RPN #118 acknowledged that the above-mentioned medications were required to be stored in a locked area which was exclusive for drugs.

There was risk to the safety of the residents when such medications were not placed in an area exclusive for drugs.

Sources: Observation, interviews with RN #119 and RPN #118, and residents' #001, #004, and #005 clinical records.

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