Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 3, 2015	2015_405189_0001	T-120-14	Resident Quality Inspection

Licensee/Titulaire de permis

YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE SCARBOROUGH ON M1V 5L3

Long-Term Care Home/Foyer de soins de longue durée

YEE HONG CENTRE - MARKHAM
2780 BUR OAK AVENUE MARKHAM ON L6B 1C9

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

NICOLE RANGER (189), THERESA BERDOE-YOUNG (596), TIINA TRALMAN (162)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 14, 15, 16, 19, 20, 21, 23, 26, 27, 2015.

The following Critical Incident inspections were conducted concurrently with RQI: T-1398-14, T-1627-14

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Food Service Manager (FSM), Facilities Manager, Registered Dietitian (RD), registered staff, activation staff, facility aide, dietary staff, personal support workers (PSW), housekeeper/laundry aide, Resident Council president, Family Council co-chairs, volunteers, residents and family members.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #03 was assessed on January 22, 2015, by the registered dietitian (RD). The assessment identified the resident requiring a minced texture when refusing to wear his/her denture or not tolerating cut up foods. The inspector observed that the resident received a minced texture at the lunch meal on January 27, 2015, for which there was no diet order.

Resident #03's current diet order dated January 22, 2015, indicates to continue with a modified diabetic diet /cut up texture (1/2 x at lunch and dinner). The written care plan indicates modified diabetic diet/cut up texture to offer minced if resident refused to put on the denture and offer ½ portion at lunch and supper. The servery diet information sheet updated January 26, 2015, indicates, Mod Diab Cut up ½ at lunch and dinner and offer minced texture if refuse to wear denture. There is a discrepancy of directions between the diet order, written care plan and servery diet information sheet. [s. 6. (1) (c)]

2. Resident #09 was assessed on July 14, 2014, to receive a regular diet/cut up texture (1.5 x portions at lunch & supper). The diet order dated July 14, 2014, indicates regular diet/cut up texture. The written care plan indicates to follow current diet order recommendation regular diet/finely cut up texture (1.5 x at meal). The servery diet information sheet indicates 1.5 x portions. On January 20, 2015, the inspector observed the resident to receive one and one half portion at the lunch meal for which there was no diet order. There is a discrepancy of directions between the diet order, written care plan and servery diet information sheet. [s. 6. (1) (c)]

3. During the observed lunch meals on January 20 and January 26, 2015 for residents #03 and #09, the inspector observed a lack of directions to staff portioning for residents identified as requiring one-half and one and one-half serving sizes.

Interview with identified dietary aides (DA) revealed that they estimate portion sizes for menu items at point of meal service for the identified residents. Interview with the food service manager (FSM) confirmed that the menu does not include serving sizes for the identified residents requiring one-half and one and one-half portions. The FSM confirmed there is no direction for portioning menu items requiring one-half and one and one-half serving sizes to guide staff. [s. 6. (1) (c)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

There was no collaboration with the RD when resident #03 experienced mouth pain, a change in food intake and diet texture with an order.

On January 21, 2015, the inspector observed resident #03 sitting at the dining table and not eating his/her meal. The inspector also observed the resident's denture was placed on the table. The resident demonstrated to the inspector by shaking his/her head and pointing to the denture and then pointing to his/her opened mouth. According to the written care plan, the resident receives a modified diabetic diet/cut up texture.

Interview with an identified registered staff member revealed that the resident has been complaining of mouth pain since early January 2015, and has been removing his/her denture at meal times and not eating well. The staff member indicated prior to the meal

service, the resident did not indicate pain and was served a cut up meal. The registered staff also indicated that the resident is given a minced texture at times when complaining of mouth pain or refusing to eat with denture. The registered staff then requested a minced texture meal. The resident was observed to eat the meal. The registered staff indicated that a referral was made to the physician early January 2015.

A record review revealed that on January 8, 2015, nursing documented that resident #03 "complained of mouth pain on hard palate and that the MD will be informed." Further review revealed that between January 8 and January 21, 2015, the resident's intake was noted as one-half to two-thirds. Interview with the registered staff member on January 23, 2015, revealed that a referral was forwarded to the RD on January 21, 2015, to assess the resident's dental issues affecting nutrition intake.

Interview with the RD revealed that a referral was not received until January 21, 2015. The RD confirmed that a referral should have been made to address the resident's change in condition related to mouth pain, change in eating ability, not eating with denture and reduced intake. [s. 6. (4) (a)]

5. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On January 21, 2015 at 11:05 a.m., resident #06 was observed to be dressed in a blue hospital gown. Record review of resident #06's written plan of care dated January 14, 2015, confirmed that resident should be dressed appropriately in street clothes, and did not mention dressing the resident in a hospital gown. Interview with an identified PSW and RPN revealed that the resident remains in the hospital gown all day due to difficulty dressing the resident related to stiffness of the body and contracted limbs. [s. 6. (7)]

6. Resident #03's current diet order dated January 22, 2015, indicates to continue with a modified diabetic diet/cut up texture (1/2 x at lunch and dinner). The written care plan indicates modified diabetic diet/cut up texture. To offer minced if resident refused to put on the denture and offer ½ portion at lunch and supper. The servery diet information sheet updated January 26, 2015, indicates "Mod Diab Cut up ½ at lunch and dinner and offer minced texture if refuse to wear denture."

Interview with an identified dietary aide confirmed the resident was provided regular portion of the minced meal instead of one-half serving. [s. 6. (7)]

7. During the observed lunch meals on January 20 and January 26, 2015 for residents #03 and #09, the inspector observed a lack of directions to staff portioning for residents' identified as requiring one-half and one and one-half serving sizes.

Interview with identified dietary aides (DA) revealed that they estimate portion sizes for menu items at point of meal service for the identified residents. Interview with the FSM confirmed that the menu does not include serving sizes for the identified residents requiring one-half and one and one-half portions. The FSM confirmed there is no direction for portioning menu items requiring one-half and one and one-half serving sizes to guide staff. [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 plan of care set out clear directions to staff and others who provide direct care to the resident, to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Recreational and Social Activities program includes: the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends, and the communication of the schedule to all residents and families.

A review of the recreation and social activities calendar for November 2014 to January 2015, revealed that activities are not provided consistently in the evenings and weekends for the residents residing on the second floor secured unit.

An interview with an identified activation staff member confirmed that evening programs are not available on each floor daily, including weekends. Furthermore, residents from the second floor may be not be taken to activities held on other floors unless a family member is available to take the resident to the floor. An interview with the Executive Director(ED) confirmed the above and indicated that the home is reviewing their plan to increase activities during the evenings and weekends for all residents. [s. 65. (2) (b)]

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 Recreational and Social Activities program include: The development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends, and the communication of the schedule to all residents and families, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On January 21, 2015 at 11:50 a.m., during medication administration on an identified unit, the inspector observed empty medication pouches with residents' personal health information visible (name, room number, names of medications prescribed) in a small container on top of the medication cart. At 11:55 a.m.,on an identified unit, the inspector observed another instance where empty medication pouches with residents' personal health information were visible in the garbage of the medication cart. On both occasions the medication pouches were visible to anyone passing by.

Interview with two identified registered staff and the Assistant Director of Resident Care (ADRC) revealed that the empty medication pouches should be torn or cut so that the resident's name is removed, then discarded in the garbage container of the medication cart. The registered staff and ADRC confirmed that the empty pouches observed by the inspector were not torn or cut properly, in order to protect residents' personal health information. [s. 3. (1) 11. iv.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

Record review of the home's policy CAD-VII-08 entitled Zero Tolerance of Abuse, with a reviewed/revised date of October 2014, gives direction regarding investigation of suspected or witnessed abuse/neglect. It indicates that the employee(s) shall immediately be placed on a Leave of Absence with pay from active duty pending further investigation with the possibility of discipline or discharge to follow. Record review of investigation notes and interviews with the Director of Resident Care (DRC), Executive Director (ED) and resident # 50 confirmed that an identified staff member was not immediately placed on a leave of absence. The identified staff continued to work on the same floor where the resident resides. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring volunteers who are 18 years of age or older.

Record review of the home's active volunteer applications and interview with the ED, revealed that a criminal reference check was not conducted for an identified volunteer, who currently volunteers in the home and is over the age of 18 years. [s. 75. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

A review of the home's 2013 satisfaction survey revealed that there were no questions on the satisfaction survey pertaining to programs provided in the home such as: continence care, skin and wound care, occupational therapy, physiotherapy, falls/restraints.

Interview with the ED confirmed that questions measuring satisfaction with clinical programs provided in the home were not included in the 2013 satisfaction survey. [s. 85. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review of the home's investigation related to an alleged abuse by resident #50 indicated that the resident's SDM was not notified until 48 hours later. Interview with the Director of Resident Care (DRC) confirmed that resident #50's SDM was not notified within 12 hours of becoming aware of the alleged abuse. [s. 97. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home are considered in the evaluation of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents.

Record review and interview with the ED revealed that the home did not include the analysis of resident #50's allegation of abuse in the evaluation of the home's abuse policy. There was no written evaluation documented and available. [s. 99. (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participates in the implementation of the infection prevention and control program.

On January 14, 2015, during the lunch meal on an identified unit, the inspector observed a staff removing soiled dishes from an identified resident's dining table, scraping the plates, and then reaching into the food waste bin to remove utensils that had fallen in. The staff member returned to the dining table to resume feeding an identified resident. The staff member did not follow hand hygiene practices. The inspector intervened before the staff could resume feeding the resident. The staff member confirmed he/she did not practice hand hygiene practices after handling soiled dishes.

A review of the home's policy CIPAC-II-06 entitled, Hand hygiene and hand care, revised September 2014, indicates hand hygiene shall be consistently carried out by all staff while conducting resident/client activities. [s. 229. (4)]

Issued on this 13th day of February, 2015

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

Original report signed by the inspector.