Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Oct 2, 2020	2020_715672_0013	018561-20	Critical Incident System

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

JENNIFER BATTEN (672)

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): September 23, 2020

The following intakes were completed during this inspection:

One intake related to a Critical Incident Report regarding a COVID-19 outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Activation Support Workers and residents.

The inspector reviewed clinical health records of identified residents, COVID-19 screening logs, staffing and pandemic plans, Infection Prevention and Control assessments and internal audits. The Inspector observed staff to resident care and infection control practices.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that lunch meals were served to residents at a palatable temperature.

The home was declared to be in a COVID-19 outbreak and as a result, residents were isolated to their rooms and received meals via tray service. An observation of the lunch meal noted the meals were being served on disposable paper plates and drinks were served in disposable cups, none of which were covered. The food and fluids were then placed on plastic cafeteria style trays and served to the residents in their bedrooms. During the meal observation, resident #010 complained that they could not finish or enjoy their lunch meal, due to it being served cold, especially the soup and tofu and discarded over half the meal. Resident #010 indicated that since the licensee had moved to tray service for all meals, they had experienced multiple meals served at unpalatable temperatures for breakfast, lunch and dinner, due to the foods becoming too cold to enjoy. Resident #010 indicated that staff were not following up with residents during meals to assess how they were doing or inquire if any assistance was required, such as offering to reheat a meal.

Resident #004 also indicated they did not finish their meal as they did not enjoy the food or hot fluids due to the temperatures being too cold. Resident #004 verified the information provided by resident #010, related to experiencing multiple meals served at unpalatable temperatures for breakfast, lunch and dinner due to the foods being too cold to enjoy, since the licensee had moved to tray service for all meals.

While receiving assistance with their meal from PSW #103, resident #008 indicated that

the meal was not at an enjoyable temperature, due to the soup, meal and hot beverages being served cold.

During separate interviews, PSWs #102, #103 and Activation Support Worker #101 indicated the procedure staff were following was to serve meal trays, which consisted of uncovered meals being served to every resident on the unit. Once every resident had received their meal tray, staff would then assist the residents who required physical assistance with their meals. These staff members stated that since tray service was initiated, they had heard complaints from multiple residents that the foods were not being served at the temperatures they should be. By serving meals to residents at unpalatable temperatures, residents were at increased risk of having poor food and fluid intakes.

Sources: Inspector observations during a lunch meal; interviews with residents #004, #008 and #010; staff interviews with PSWs #102, #103 and Activation Support Worker #101, amongst others. [s. 73. (1) 6.]

2. The licensee failed to ensure that lunch meals were not served to residents #006, #007, #008 and #009 until a staff member was present to assist the residents with their meals.

The home was declared to be in a COVID-19 outbreak and as a result, residents were isolated to their rooms and received meals via tray service. An observation of the lunch meal noted the meals were being served to all residents on the unit, and then staff began assisting the residents who required physical assistance with their meals. This led to some residents having meals served to their rooms prior to receiving the required assistance from staff to consume their lunch meal. Residents #006, #007, #008 and #009 had their lunch meals served to them prior to a staff member being available to provide the required assistance. During separate interviews, PSWs #102, #103 and Activation Support Worker #101 indicated the procedure staff were following was to serve meal trays to every resident on the unit first and then begin assisting the residents who required assistance with their meals. By serving meals to residents who require assistance prior to someone being available to provide the assistance required, resident’s emotional health and dignity may be negatively affected, along with increased risks of poor food and fluid intakes.

Sources: Inspector observations during a lunch meal; written plans of care for residents #006, #007, #008 and #009; staff interviews with PSWs #102, #103 and Activation Support Worker #101, among others. [s. 73. (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 meals are served at palatable temperatures and are not served to residents who require physical assistance until the required assistance is available, to be implemented voluntarily.

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.