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
Mar 10, 2022	2022_919026_0003	017281-21	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

JULIE DUNN (706026)

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): March 1, 2, 3 and 7, 2022.

The following intake was completed in this critical incident inspection:
Log # 017281-21, CIS # 2876-000005-21 was related to a resident's unwitnessed fall.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Environmental Support Workers, Physiotherapist, the Infection Prevention and Control (IPAC) Manager, the Assistant Director of Care (ADOC), and the Director of Care (DOC).

Inspector #565 was also present for the inspection.

During the course of the inspection, the inspector toured the long-term care home, observed IPAC practices, observed care areas and resident rooms on units, reviewed the long-term care home's relevant policies and procedures and investigative records, and reviewed resident clinical records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary. LTCHA s. 6. (10) (b)

1. A resident had an unwitnessed fall. The resident was transferred to hospital and there was a significant change in the resident's health condition.

An intervention in the resident’s care plan that was initiated more than six months ago stated a device was to be in place, with no revision date documented. The device was not in place during two separate observations. A staff member stated the device would not be appropriate for the resident. The DOC verified that the intervention should have been reassessed in the resident care plan.

2. A second resident’s care plan included an intervention that was initiated more than six months ago, stating a device was to be in place, with no revision date documented. The device was not observed to be in place. A staff member verified that the resident does not use the device and the care plan intervention should have been reassessed and revised.

3. A third resident’s care plan included an intervention that was revised more than six months ago, stating a device was to be in place. On observation, the device was not in place. A staff member verified that the resident does not use the device and the care plan intervention should have been modified.

By failing to ensure the residents were reassessed and the care plans reviewed and revised, there was risk of harm to the residents.

Sources:
Care plans for three residents; observations; interviews with the DOC and staff. [s. 6. (10) (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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of:
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
O. Reg. 79/10 s. 107. (3) 4.

Specifically, the licensee failed to inform the Director no later than one business day after an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

A resident stated they were experiencing pain. After an assessment by an RN, it was discovered that the resident had an unwitnessed fall. The resident was transferred to hospital and there was a significant change in the resident's health condition.

A Critical Incident report was submitted to inform the Ministry of Long Term Care of the incident more than one business day later.

Sources:
The resident’s clinical record, interviews with staff. [s. 107. (3)]

Issued on this 15th day of March, 2022

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

Original report signed by the inspector.