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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 3, 2023
Inspection Number: 2023-1361-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Markham, Markham

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Eric Tang Digitally signed by Eric Tang Date: 2023.10.12 08:12:55 -04'00'

Additional Inspector(s)
Deborah Nazareth (741745)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11-15, 18, 20-21, 2023.

The following intake(s) were inspected:
- An intake related to a Proactive Compliance Inspection.

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Quality Improvement
Resident Care and Support Services
Residents' and Family Councils
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that a door leading to a non-residential area was kept closed and locked when it was not being supervised by staff.

Rationale and summary

During observations in the Long-term Care Home (LTCH) on September 11, 2023, on the fifth floor south wing, the door to the soiled utility room was propped open. Tongue depressors were placed in the door latch, preventing it from being locked. Staff were not present in the room or immediate vicinity. The room contained an opened bottle of disinfectant, and bins with soiled linens and used incontinent products. A Registered Nurse (RN) acknowledged that the staff should have locked the soiled utility room and they removed the tongue depressors and closed the door. The Infection Prevention and Control (IPAC) Manager confirmed the expectation was that the soiled utility room was to be kept closed and locked when not in use.

There was a safety risk to residents when the soiled utility room was left opened and unsupervised.

Sources: Observations, and staff interviews.
[741745]

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)

The licensee has failed to ensure air temperature was measured under subsection (2) and documented in writing at least once every morning, once every afternoon between 12 p.m. and 5 p.m., and once every evening or night, from October 2022, to April 2023.

Rationale and summary

As per the home's policy titled, Preventing and Managing Heat-Related Illness Plan, air temperature was to be taken three times a day and to be documented on the Air Temperature Check Form. A record review was conducted but the Air Temperature Check Forms from October 2022, to April 2023, were missing.

The Facility Manager (FM) asserted that the home's air temperature was to be measured and documented three times a day, from May 15 to September 15, of each year. The FM was unaware of the requirements outside of the identified time period.

There was a risk and impact to the residents as there might be a fluctuation of air temperature and impacting the residents' quality of life

Sources: the home's air temperature check forms, and interview with the FM. [529]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee failed to ensure a staff who had received training under subsection (2) receive retraining in the areas mentioned in that subsection on an annual basis, specifically, whistle-blowing protection and duty to make mandatory reports.

Rationale and summary

A review of the home's Zero Tolerance of Abuse policy indicated that all staff were to receive annual retraining on whistle-blowing protection and the duty to make mandatory reports. The 2022 training records indicated that a staff had only completed their training in April 2023. Additionally, the identified staff had worked multiple shifts in December 2022, based on the work schedule reviewed.

The Director of Resident Care (DRC) asserted that the training was to be completed via an online training platform, Learnici. The staff was expected to have completed their training on whistle-blowing protection and the duty to make mandatory reports in 2022. There was no reason identified for the staff's late completion of the required training.

There was a potential risk and impact to the residents as the staff might not have

provided care and services based on the 2022 training material.

Sources: 2022 electronic staff training records, the staff's work schedule, Zero Tolerance of Abuse policy, and interview with the DRC.
[529]

WRITTEN NOTIFICATION: Additional training - direct care staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee failed to ensure the staff received their annual training in all areas required under subsection 82 (7) of the Act, specifically, the falls prevention and management and pain management.

Rationale and summary

A review of the home's Staff Training and Development Plan indicated that direct care staff were to receive annual training on falls prevention and management, and pain management. Direct care staff were defined as employees that provided direct care to the residents such as PSW. A review of the 2022 training record indicated that the staff had only completed their training in April 2023. Additionally, the identified staff had worked multiple shifts in December 2022, based on the work schedule reviewed.

The DRC asserted that the training was to be completed via an online training platform, Learnici. The staff was expected to have completed their training on falls prevention and management, and pain management in 2022. There was no reason identified for the staff's late completion of the required training.

There was a potential risk and impact to the residents as the staff might not have provided care and services based on the 2022 training material.

Sources: home's 2022 electronic training records, the staff's work schedule, home's Staff Training and Development Plan policy, and interview with the DRC.
[529]