Ontario

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

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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 2, 2024	
Original Report Issue Date: March 5, 2024	
Inspection Number: 2024-1361-0001 (A1)	
Inspection Type: Critical Incident	
Licensee: Yee Hong Centre for Geriatric Care	
Long Term Care Home and City: Yee Hong Centre - Markham, Markham	
Amended By Nicole Lemieux (721709)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to: rescind CO #001 for inspection #2024_1361_0001.

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Lead Inspector Suzanna McCarthy (000745)	**Additional Inspector(s)** Nicole Lemieux (721709)
Amended By Nicole Lemieux (721709)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to: rescind CO #001 for inspection #2024_1361_0001.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29-31, 2024, and February 1, 2, 5-8, 2024

The following intake(s) were inspected during this Critical Incident Inspection:

- One intake related to alleged improper care of a resident.
- Two intakes related to the unexpected death of residents.

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

Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (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:
1. Communication of the seven-day and daily menus to residents.

The licensee failed to ensure that the correct 7 day menu was posted in a dining room.

Rationale and Summary

The inspector observed the incorrect weekly menu posted for two types of cultural meals on the bulletin boards in a resident dining area. The correct daily menus were observed to be posted in the dining room. Dietary staff confirmed that the weekly menus displayed were out of cycle and should have been updated to reflect the correct cycle.

Failure to communicate the correct weekly menu to residents may decrease the resident's enjoyment of the meal service.

The correct weekly menu cycle was observed to be posted in dining room on February 6, 2024.

Sources: Observations, interview with staff. [000745]

Date Remedy Implemented: February 6, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the two fridges containing the resident’s personal food items in an activity room were kept locked at all times.

Rationale and Summary
During an observation, two resident fridges in an activity room were noted to have signage indicating that the fridges were to be kept locked at all times. Both were observed to have padlocks in the unlocked position. Registered staff confirmed to the Inspector that the fridges were to remain locked and stated that staff had been

busy and had not had sufficient time to ensure the fridges were locked. No residents were observed to be attempting to access the unlocked fridges.

The staff member showed the Inspector the fridges which contained various containers of resident food items and then closed and secured the locks on both fridges.

Sources: Observations, interview with staff. [000745]

Date Remedy Implemented: February 2, 2024

WRITTEN NOTIFICATION: REQUIREMENTS RELATED TO RESTRAINING BY A PHYSICAL DEVICE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2)
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.)
5. That the resident is released and repositioned any other time when necessary

based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

The licensee has failed to ensure that the following requirements were met where a resident was being restrained by a physical device, under section 35 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

4. That the resident is released from the physical device and repositioned at least once every two hours.

5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.

6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Rationale and Summary
During an observation, a resident was observed to have a loosely fitted restraint. At the time of observation, the resident was being provided with feeding support by a staff member who reported that the restraint had been placed in the loosened position as the resident frequently moves in their mobility device. The restraint was observed to be in the same loosened position during three subsequent observations. The resident had impaired physical and cognitive function.
The home's policy titled "Minimizing restraints and confinement of residents" restraints are defined as: all devices used by the home that restrict freedom of movement or normal access to one's body. A resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care. The use of a physical device from which a resident is both physically and cognitively able to release themselves is not a restraining or confining of the resident.

A review of the resident's records demonstrated the absence of the following required documentation for the application of a physical restraint: physician's order for the restraint, signed consent from the resident's substitute decision maker (SDM), record of alternatives explored prior to the application of the restraint, record of the resident being monitored on an hourly basis by a registered staff or a designate, a record of the resident being released from the restraint every two hours (at a minimum), a record of the resident being repositioned in relation to the restraint, and a record of the reassessment of the effectiveness of the restraint. The absence of these materials was also confirmed during an interview with the Assistant Director of Resident Care (ADRC).

The Physiotherapist (PT), Occupational Therapist (OT), and ADRC verified that the restraint should be worn in a way that it is close to the resident's body. Failure to maintain the restraint in this manner created risk of harm to the resident. The OT and

PT both reported that the use of this type of restraint was uncommon due to the increased risk of harm for residents. The OT and PT also confirmed that the procedure was to trial alternative restraints prior to the application of this form restraint however there was no record of any alternatives being explored in the resident's clinical records, the absence of records was also confirmed by the ADRC.

The OT asserted that the device was a Personal Assistance Service Device (PASD) and that the resident was able to release the restraint at will. The Inspector, along with Inspector #721709, accompanied the OT to the dining room to have them demonstrate the resident's ability to release the device of their own accord. After repeated verbal and physical prompts from the OT, the resident failed to do so.

The manufacturer's instructions specified that if a resident has difficulty releasing the equipment it was considered a restraint and was not to be used.

Failure to ensure that all requirements are met for the application, use and monitoring of restraints impacted the resident's freedom of movement and created increased risk injury or death for the resident.

Sources: Resident's clinical records; interviews with staff; observations; Minimizing restraints and confinement of residents policy; manufacturer's instructions. [000745]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that a registered staff utilized proper techniques while providing a resident with feeding support.

Rationale and Summary
During a dining observation, the Inspector observed a registered staff member standing beside a resident as they provided feeding support. The registered staff reported that they were standing due to a medical condition. The registered staff acknowledged that standing to feed the resident was an improper feeding technique and reported that they would cease the practice immediately. A short time later, the Inspector observed the same registered staff to still be standing to feed the resident despite the earlier discussion.

The ADRC reported that unless a staff has an accommodation in place, they are to be seated when providing feeding support to residents. The ADRC confirmed that standing to feed a resident increased the risk of choking events for the resident. The ADRC further confirmed that there was no accommodation in place for the registered staff member and that they should have been seated to provide feeding support to the resident as per the home's policy.

Failure to engage in proper feeding techniques, specifically sitting to feed the resident, put the resident at increased risk of experiencing a choking event.

Sources: Observations, interviews with staff. [000745]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (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.

The licensee failed to ensure that a resident was not served a meal until staff were available to provide the resident with the required feeding support.

Rationale and Summary
During an observation in a resident dining area, a resident's meal tray was placed on their table without staff present to provide feeding support. The resident's lunch tray was observed to be sitting on the table for an extended period of time during which time the resident was not provided with feeding support.

The LTCH's directive titled: Best Practices for Promoting Safe Feeding stated "Any resident requiring assistance with eating or drinking is not served a meal until assistance is available."

The ADRC confirmed that resident's food should not sit on the table for more than 5 minutes without staff available to provide feeding support. Food Services staff confirmed that the expectation was that a resident's meal was not left to sit for more than 5 minutes as after that length of time, the food will no longer be consumed at the intended temperature and there was a potential for contamination.

Failure to ensure that a resident was not served a meal until there was sufficient staff to provide the required support decreased the enjoyment of the dining experience and increased the potential risk of food contamination.

Sources: Observations, resident's care plan, interviews with staff and directive titled Best Practices for Promoting Safe Feeding (Appendix A). [000745]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed of the unexpected death of a resident.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director for the unexpected death of a resident. The Ministry of Long-Term Care (MLTC) after hours pager was not contact about this incident and the ADRC confirmed that the incident was not immediately reported to the Director.

Failing to immediately report the unexpected death of a resident to the Director had no risk or impact to the resident.

Sources: CI and interview with ADRC. [721709]

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (8) (a)
Emergency plans
s. 268 (8) The licensee shall ensure that the emergency plans for the home are evaluated and updated,

(a) at least annually, including the updating of all emergency contact information of the entities referred to in paragraph 4 of subsection 268 (4); and

The licensee failed to ensure that the emergency plans for the home, specifically the code blue – medical emergency plan, was evaluated and updated at least annually.

Rationale and Summary
A CI was submitted to the Director for the unexpected death of a resident.

The home's medical emergency plan, specifically code blue –medical emergency plan was reviewed. The last review date of the plan was June 2021. The ARDC confirmed that was the last date the plan was evaluated and updated.

Failing to evaluate and update the code blue – medical emergency plan posed a potential risk and impact to the residents as the home might not have utilized current practices to support residents during a medical emergency.

Sources: The home's Code Blue – Medical Emergency policy, reviewed June 2021, and interview with the ARDC. [721709]

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (10) (d)
Emergency plans
s. 268 (10) The licensee shall,
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

The licensee failed to ensure a written record of the testing of the emergency plans and of the changes made to improve the plans, specifically the code blue plan, was kept.

Rationale and Summary
A CI was submitted to the Director for the unexpected death of a resident.
The home's medical emergency policy, specifically Code Blue – Medical Emergency policy was reviewed.

On several occasions, the Inspector requested the written record of testing and any changes made to improve the plans from the home. Records including the emergency disaster planning schedule, as well as attendance records for staff for suction training/code blue training were provided. No records to demonstrate testing and the changes made to improve the plans were provided prior to the completion of the inspection. The ARDC confirmed that the failure to provide records substantiated that there was no evidence to support the testing and changes made to improve the plans.

Failing to test and keep a written record of changes or improvements for the code blue – medical emergency plan posed a potential risk and impact to the residents as the home may not have utilized current practices to respond to and support residents during a medical emergency.

Sources: The home's Code Blue – Medical Emergency policy, the home's Emergency and Disaster Planning schedule, the home's attendance records for suction training/code blue training, and interview with the ADRC. [721709]

(A1)
The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.