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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Aug 12, 2016	2016_511586_0005	008832-14	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 - MISSISSAUGA
5510 Mavis Road MISSISSAUGA ON L5V 2X5

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

JESSICA PALADINO (586)

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): August 11, 2016.

Critical Incident System (CIS) Inspection #008832-14 re: Falls Prevention & Management was conducted.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), the Physiotherapist (PT), the Occupational Therapist (OT), and a Registered Practical Nurse (RPN).

During the course of the inspection, the inspector: reviewed the home's internal investigation notes, Falls Committee Meeting minutes, policies and procedures, and resident electronic and paper health records, and conducted interviews with staff.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has a plan of care that is based on interdisciplinary assessment of the following with respect to the resident: health conditions, including risk of falls.

Resident #001 experienced four falls in 2014. On an identified date in November 2014, the fall resulted in a significant injury. According to the Coroner, the resident's injury caused their death. Review of progress notes and interview with the PT, OT and RPN #001 on August 11, 2016, confirmed that resident was at a high risk for falls. Review of the resident's documented plan of care, which front line staff used to direct care, confirmed that there was no section regarding the resident's falls risk or interventions between May and November 2014. This was confirmed by the ED, OT and PT. The ED confirmed that the resident went over six months without having a falls risk section in their plan of care, providing no direction to staff on the floor that provided care to the resident. [s. 26. (3) 10.]

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 every resident has a plan of care that is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: health conditions, including risk of falls, to be implemented voluntarily.

WN #2: 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 failed to ensure the home's falls prevention policy was complied with.

The home's policy "Falls Prevention and Management Program" (policy number CIP-I-01, last revised June 2016) directed staff to "initiate a post fall huddle in the same shift with available staff to determine the cause of the fall".

On an identified date in November 2014, resident #001 was found on the floor after having experienced a fall that resulted in a significant injury. Interview with the home's ED on August 11, 2016, confirmed that it was the expectation of the home for staff to complete a "Post-Fall Huddle Tool" after a resident experienced a fall, and confirmed that this was not completed after resident #001's fall in November. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 12th day of August, 2016

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

Original report signed by the inspector.