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
Feb 21, 2017	2017_370649_0003	000550-17	Resident Quality Inspection

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

JULIEANN HING (649), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 16, 17, 18, 19, 23, 24, 25, and 26, 2017.

The following Critical Incidents (CI) inspections were conducted concurrently with this RQI: 013812-16 and 034611-16

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Assistant Director of Resident Care/resident assessment instrument (ADRC/RAI) coordinator, facility manager (FM), food service manager (FSM), registered nurse (RN), registered practical nurse (RPN), personal support worker (PSW), physiotherapist (PT), housekeeper, volunteer, dietary aide (DA), Family Council Co-Chairs, Residents' Council Chairman, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, reviewed health records, meeting minutes, schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The home submitted a Critical Incident (CI) report to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in April 2016, reporting a fall. Resident #006 had fallen out of his/her wheelchair and sustained an injury while being pushed in the corridor by a staff member on an identified date in April 2016.

Record review of resident #006's written plan of care directed staff to use a device on top of wheelchair cushion to prevent sliding while in the wheelchair. The resident's kardex in Point of Care (POC) did not include this intervention.

On an identified date in January 2017, the inspector observed resident #006 propelling in his/her wheelchair up and down the corridors; the device was not observed on the resident's wheelchair.

Interview with personal support worker (PSW) #131 and Registered Practical Nurse (RPN) #132 stated that the resident didn't need to use the device anymore.

Interview with PSW #141 and RPN #142 revealed that resident #006 needs the device to prevent him/her from sliding. RPN #142 stated that the resident moves around a lot in the wheelchair and is at risk for falls. PSW #141 stated that he/she applied the device on the resident's wheelchair at the beginning of the day shift and had been using it for the resident all along.

Interview with the Physiotherapist (PT) revealed that the staff should be using the device on the resident #006's wheelchair as it is indicated in the plan of care.

Interview with the Director of Resident Care (DRC) revealed that the resident's kardex should reflect the same intervention as the care plan regarding use of the device, and he/she will remind the registered staff to bring residents' care plan interventions forward to the kardex, to ensure clear direction for Personal Support Worker (PSW) staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During stage one of the Resident Quality Inspection (RQI), nutrition and hydration triggered for resident #004.

Observation on an identified date in January 2017, revealed that one show plate consisted of two choices. Choice one: steamed pork slices with preserved vegetables, rice and Korean cabbage and choice two: baked fish fillet, and rice. Residents may choose either choice one or two or both choices. The two portion sizes of meats offered is equal to one serving of meat.

Resident #004 was observed to have received both servings of each meat at dinner and had not been offered a choice of the specified meat serving at dinner.

Record review of resident #004’s most current plan of care under the eating section directed staff to provide the resident with specified meat serving at dinner.

Interview with resident #004 on a specified date in January 2017, revealed that he/she had not always received the specified meat serving at dinner.

Interview with PSW #107 and dietary aide (DA) #108 revealed that resident #004 had not been offered the specified meat serving at dinner on the identified date in January 2017. PSW and DA told inspector that the serving sheet indicated that resident #004 should have received a specified meat serving of his/her choice at dinner.

Interview with Assistant Director of Resident Care (ADRC) #109 confirmed that the specified meat serving had not been offered or served at dinner. [s. 6. (7)]

3. The home submitted a CI report to the MOHLTC on an identified date in April 2016, reporting a fall. Resident #006 had fallen out of his/her wheelchair and sustained an injury while being pushed in the corridor by a staff member on an identified date in April 2016.

Record review of resident #006's written care plan and kardex under the falls prevention section directed staff to ensure that the call bell is in easy reach when resident is in the bedroom or bathroom.

On an identified date in January 2017, the inspector observed resident #006 laying in bed with two side rails up, and the call bell on the floor.

Interview with PSW #128 revealed that the call bell was accessible to the resident when he/she last checked the resident at an identified time, PSW #128 immediately pinned the call bell to the resident's pillow and agreed that the call bell should be accessible to the resident at all times as indicated in the resident's plan of care. [s. 6. (7)]

4. Record review of resident #006's written plan of care and kardex under the toilet use section directed staff to use a specified device for transfer from wheelchair to spa room for toileting.

Interview with PSW #141 revealed that he/she used a specified device with another staff to toilet resident #006 at an identified time and was not aware that the resident's care plan had been updated to reflect a different device in the last two days. PSW #141 stated that he/she should have checked the resident's care plan for updates before providing care. [s. 6. (7)]

5. The licensee has failed to ensure that the resident was assessed 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 the care set out in the plan is no longer necessary.

During stage one of the RQI, skin and wound triggered for resident #006.

Record review of resident #006's most current plan of care under skin section directed staff to apply topical medications as per the physician's orders.

Interview with RPN #132 revealed that the medications had been discontinued on an identified date in May 2016, and the care plan had not been updated.

Interview with the ADRC #109 revealed that resident #006's care plan had not been reviewed and revised when resident's care needs changed. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is provided to the resident as specified in the plan, and 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways or doors that residents do not have access to must be kept closed and locked and equipped with a door access control system that is kept on at all times.

On an identified date in January 2017, during the tour of the home, the inspector pushed and opened the fourth floor south west door leading to a stairway, without using a door access control card; an alarm sounded when the door opened. There were no residents nearby.

Observation of the unlocked stairway door and interviews with Registered Nurse (RN) #133 and housekeeper #134 revealed that the stairway door was unlocked and should only be opened by use of a door access card. They reported that the unlocked stairway door posed a safety risk for residents as it was easily able to be opened by pushing it. RN #133 stated that he/she would inform maintenance immediately.

The facility manager (FM) later reported to the inspector that the contact between the fourth floor stairway door had been adjusted and now accessible only by the use of the door access control card.

The ARDC #115 reported that an immediate head count had been done and all residents had been accounted for and stated that the door had been fixed. [s. 9. (1) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

Under O. Reg. 79/10, s.5 the definition of "neglect" in subsection 5 of the Act, "neglect"

means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In April 2016, a CI report was submitted to the MOHLTC related to resident #006, who sustained a fall on an identified date in April 2016, while being pushed in his/her wheelchair in the corridor by PSW #128. Suddenly resident #006 put his/her feet on the floor and subsequently fell forward out of the wheelchair landing onto the floor.

Record review of the resident's written plan of care stated that the resident could propel the wheelchair by him/herself in short distances.

Interview with PSW #128 revealed that on an identified date in April 2016, he/she was preparing resident #006 for his/her shower in the spa room. The resident self propelled him/herself in the wheelchair down the corridor towards the spa room, told PSW #128 that he/she was tired and asked to be pushed in the wheelchair by the PSW. PSW #128 asked the resident to raise both legs and started to push him/her in the wheelchair towards the spa room when the resident suddenly put both feet down on the floor and fell forward then to the side, out of the wheelchair. PSW #128 called the registered staff who attended and assessed the resident who was later sent to hospital for further assessment. PSW #128 reported that he/she did not think about using an identified device on the resident's wheelchair while pushing him/her, and stated that he/she should have put the device on the resident's wheelchair to maintain the resident's safety while pushing him/her to the spa room.

Interview with RPN #136 reported that he/she attended to resident #006 on an identified date in April 2016, after he/she had sustained an injury while being pushed by PSW #128. He/she completed a head to toe assessment, vital signs and the resident complained of pain. The physician and family were notified and the resident was immediately transferred to the hospital. The resident returned the following day with a diagnosis of a medical condition, as a result of the fall. RPN #136 reported that when staff are pushing residents in wheelchairs an identified device should be used for safety. The RPN stated that resident #006's injury could have been prevented by using the device.

Interview with ADRC #109 confirmed that resident #006's injury in the corridor on an identified date in April 2016, could have been prevented. Once the resident verbalized to PSW #128 that he/she was tired, the PSW should have put the device on the wheelchair

before starting to push the resident. [s. 19. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented

The home submitted a CI report to the MOHLTC on an identified date in April 2016 reporting an injury. Resident #006 had fallen out of his/her wheelchair and sustained an injury while being pushed in the corridor by a staff member on an identified date in April 2016.

Record review of resident #006's written plan of care under the falls risk section, indicated that staff were to conduct safety checks every hour for the resident and the resident was high risk for falls. Record review of resident #006's assessments conducted by the PT on an identified date in April 2016, recommended monitoring at an increased frequency.

Interviews with PSWs #128 and #131 revealed that they monitor resident #006 every hour as indicated in the resident's plan of care; however they did not document as it is not included as a task in the POC documentation system.

Interview with the Director of Resident Care (DRC) revealed that PSW staff should have been documenting resident #006's hourly safety checks in the POC documentation system, as the resident was at high risk for fall. The DRC reported that he/she would remind registered staff to update residents' tasks in POC at the same time when they update care plans. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

1. During stage one of the RQI, skin and wound triggered for resident #006 related to a skin integrity concern.

Record review of resident #006's weekly wound assessments revealed that a weekly wound assessment had not been completed on an identified date in November 2016, after a skin integrity care concern had been identified in September 2016.

Interview with RPN #132 revealed that the weekly wound assessment had been missed on an identified date in November 2016.

2. During stage one of the RQI, skin and wound triggered for resident #007 related to a skin integrity concern.

Record review of resident #007's weekly wound assessments revealed that a weekly wound assessment had not been completed on an identified date in September 2016, after a skin integrity care concern had been identified in August 2016.

Interview with RPN #137 revealed that on an identified date in September 2016, the weekly wound assessment had been missed.

Interview with the ADRC #109 revealed that it was the home's expectation that the weekly wound assessments were done weekly until the skin integrity care concern had resolved for residents #005 and #007. [s. 50. (2) (b) (iv)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies, that is secure and locked.

On an identified date in January 2017, during observation of a medication administration pass the inspector observed one envelope containing $5.12, and a ring stored in the double-locked section of the medication cart containing narcotics.

RPN stated that the money was being kept to pay for a resident's hair cut, and the ring that belonged to another resident was to be picked up by family soon. The RPN stated that the ring and money should not be stored in the double-locked section of the medication cart containing narcotics. [s. 129. (1) (a)]

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.