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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 20, 2022	
Inspection Number: 2022-1404-0001	
Inspection Type: Critical Incident System	
Licensee: Yee Hong Centre for Geriatric Care	
Long Term Care Home and City: Yee Hong Centre - Mississauga, Mississauga	
Lead Inspector Parimah Oormazdi (741672)	**Inspector Digital Signature** Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2022.12.30 11:48:46 -05'00'
Additional Inspector(s) Noreen Frederick (704758)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 13, 2022
December 15, 2022
December 16, 2022

The following intake(s) were inspected:
- Intake: #00006480 - related to abuse and neglect
- Intake: #00008477 - related to falls prevention and management

The following intakes were completed in the Critical Incident System Inspection:
- Intake: #00003470 - related to falls prevention and management
- Intake: #00005356 - related to falls prevention and management

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

Infection Prevention and Control

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Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised after they fell and their care needs changed.

Rationale and summary:
The home submitted a Critical Incident System (CIS) report, when a resident had a fall incident that resulted in an injury, and transfer to hospital for further treatment. Prior to the fall incident, the resident was independent in transferring themselves and able to ambulate without assistance. After the fall incident their ambulation status has declined and they required extensive assistance for transferring ambulating.

The Long- Term Care Home's investigation notes and the post fall incident notes, indicated that resident slid on the wet floor in washroom after completing their foot care routine. Plan of care was not reviewed and revised post fall to include their foot care routine, and no additional interventions were included to address this.

The Associate Director Of Care (ADOC) and Physiotherapist, acknowledged that the resident's daily foot care routine increased the risk of fall, and their plan of care should have been revised post fall to include interventions to prevent further falls in the future. Failure to review and revise the resident's plan of care after the above mentioned fall incident which caused a change in their care needs, put them at risk of further falls in the future.

Sources: Critical incident report #2920-000010-22, resident's plan of care, progress notes, home's investigation notes, interviews with ADOC and Physiotherapist. [741672]