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

Hamilton District
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Original Public Report

Report Issue Date: January 10, 2024

Inspection Number: 2023-1404-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Yee Hong Centre for Geriatric Care

Long Term Care Home and City: Yee Hong Centre - Mississauga, Mississauga

Lead Inspector	**Inspector Digital Signature**
Jennifer Allen (706480)	Jennifer L Allen Digitally signed by Jennifer L Allen Date: 2024.01.11 11:06:38 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): **December 22, 27-29, 2023 and January 2-4, 2024.**

The following intake(s) were inspected:

- Intake: #00101543 - Complaint with concerns regarding a resident - Neglect related to following resident plan of care.
- Intake: #00102825 - Fall of a resident resulting in injury.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
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 (7)

Plan of care

Duty of licensee to comply with plan

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.

The licensee failed to ensure that the care set out in the plan of care was provided as specified in the plan.

Rationale and Summary

A. A resident was sitting in the activity room in their wheelchair. Upon observation their safety device was not connected to the resident. It was clipped to the fabric of the backrest of the wheelchair. A staff member confirmed that the clip should be clipped to the resident and immediately moved the clip onto the residents' clothing.

B. Another resident was observed sitting in the activity room on another floor in their wheelchair. Their safety device was also clipped to the fabric of the backrest of the wheelchair. Another staff member confirmed that the safety device should be

clipped to the residents clothing.
C. A third observation on a different floor dining room. Two additional residents were observed to not have their safety devices secured to their clothing. One resident had their safety device tangled in the left wheel of the wheelchair and the other resident had the safety device hung over the left side of the handle of the wheelchair behind the resident. The Assistant Director of Resident Care (ADRC) acknowledged the clips were not connected and immediately fasten the safety devices the residents.
The Director of Resident Care (DRC) confirmed that safety devices should be secured to the residents while up in their wheelchairs.
Failure to ensure that the care set out in the plan of care for the residents increased the risk to the resident's safety.
Sources: Observation of the residents; Review of residents health records, Interview with ADRC, DRC and other staff.
[706480]

WRITTEN NOTIFICATION: Plan of Care - Reassessment and Revision

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (a)
Plan of care
When reassessment, revision is required
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;

The licensee failed to review and revise the plan for care for a resident, when their

goals for Hypodermoclysis was reached.

Rationale and Summary

The physician ordered fluid infusion continuously until the resident was able to eat and drink well. Shortly after, the order was changed to fluid infusion as needed, if fluid intake was less than 800 ml/d and not eating for 2 consecutive days and to change the insertion site on bath days (remove at 0800 and reinsert at 2000).

During a specified date range, the nursing staff continued to document three times daily that the resident did not need additional fluid infusion or did not meet the order criteria to administer, until the order was stopped by the physician.

The resident's current plan of care stated the resident was a risk for dehydration relating to poor oral intake, urinary track Infection and currently receiving fluid infusion.

Upon review of the resident's plan of care by inspector on January 2, 2024, the plan of care still indicated the resident should be receiving fluid infusion.

A registered staff member stated that the resident was not receiving fluid infusion and has not in a long time and acknowledge that the order should have been discontinued earlier.

The ADRC confirmed that the plan of care should have been revised when the intervention was discontinued and the intervention should have been reviewed and revised when the resident's returned to baseline.

Failure to ensure the plan of care is reviewed and revised when the plan of care goals are met, could lead to staff uncertainty regarding the use of fluid infusion for the resident.

Sources: Resident's health records, interview with the ADRC and other staff. [706480]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

The licensee failed to ensure that the drugs were properly stored in an area of the medication cart that was secure and locked.

Rationale and Summary

A strip of medication was observed to be left on top of the medication cart and the medication cart was unlocked, and no registered staff were in the immediate area.

A registered staff member confirmed they were providing medications on the floor and apologized for leaving the medications on top of the cart and the cart unlocked and acknowledged that they should have put the medication back in the cart.

The Director of Resident Care (DRC) confirmed that all medications when not being used must be locked in the medication cart, and leaving medications on top of the medication cart unattended was not acceptable.

By not ensuring that the medications were secure and locked, residents were put at risk of accessing drugs that could potentially harm them.

Sources: observation on the floor; interview with the DRC and other staff.

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WRITTEN NOTIFICATION: Policies to be Followed

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

Policies, etc., to be followed, and records

s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,

(b) is complied with.

The licensee has failed to comply with the home's Medication Administration policy was complied with.

In accordance with O. Reg 246/22, s. 123 (2), the licensee was required to have Medication Management System policies to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Rationale and Summary

Specifically, staff did not comply with the Security and Storage of Narcotics and Controlled Substances Policy, CNU-IX-23, last reviewed April 2022.

The policy stated that two registered staff (one in-coming and one out-going) shall together count the balance of all narcotic and controlled substances at the time of every shift change, ensure all entries are complete and sign the Narcotic and Controlled Substances Administration Records.

There were four instances in December 2023, where there were missing a second nurse check. One on the third floor at 2300 hours incoming check. Three on the fifth

floor at 1500 hours incoming check, 1500 hours outgoing check, and 2300 hours incoming check.
Interview with a registered staff member confirmed that home's process for counting narcotics is two registered staff are to count together at the end and beginning of each shift.

The ADRC confirmed is it the expectation for each shift count two nurses must count, check and sign together.

Sources: Security and Storage of Narcotics and Controlled Substances Policy (CNU-IX-23, last reviewed April 2022). resident's health care records including narcotic count sheets; interviews with the ADRC and other staff.
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