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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2015;	2014_328571_0027 (A1)	O-001105-14	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 - SCARBOROUGH McNICOLL
2311 McNICOLL AVENUE SCARBOROUGH ON M1V 5L3

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

ANGELE ALBERT-RITCHIE (545) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested an extension to the compliance date, for Compliance Order #001, issued pursuant to O. Reg. 79/10, s. 9 (1) 2, as a result of the Resident Quality Inspection (RQI), conducted in October 2014. This section of legislation is related to resident accessible doors that lead to non-residential areas.

The licensee has provided a summary of progress made to date in this area, as well as an explanation of the factors that are delaying their ability to achieve full compliance by the original compliance date of February 27, 2015. The compliance date has now been amended, to reflect a new compliance date of May 29, 2015. In addition, the following statement was added to the compliance order: "The licensee will implement measures to ensure resident safety until such time as compliance with O. Reg. 79/10, s. 9 (1) is achieved."

Issued on this 23 day of February 2015 (A1)

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

Original report signed by the inspector.

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

ANGELE ALBERT-RITCHIE (545) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): October 14-17 and 20-24, 2014

Log #T-498-14 for Critical Incident 2801-000001-14 was inspected concurrently as part of this RQI.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), two Assistant Director's of Care, Facility Manager, Activation staff, Occupational Therapist, Registered Nurses, Registered Practical Nurses, Registered Dietitian, Personal Support Workers, and Housekeeping staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
2 VPC(s)
3 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. 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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. During the RQI, resident accessible (unlocked) doors leading to non-residential corridors were observed beside the nursing stations on floors 2, 3, and 4. These non-residential corridors contains a housekeeping closet and a service elevator.
In separate interviews on October 15, 2014, the DOC and Staff # 105 indicated that the doors to these non-residential hallways on floors 2,3 and 4 are not locked at any time nor are they constantly supervised.
In addition to potentially having unsupervised access to non-residential areas, a resident could also exit the home via the non-residential area. [s. 9. (1) 2.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 10. Elevators
Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. Throughout the RQI inspection, it was observed that it was possible for a Resident to access the two main elevators on the 2nd, 3rd and 4th floor by activating the elevator button. Once on the elevator, the resident cannot access floors 2-5 without a swipe card, fob or code. However, the resident could activate the ground floor and leave the nursing home via several unlocked doors. The resident could also activate the basement button and enter the basement which contains non-residential areas and unlocked doors to the outside. [s. 10. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. A review of the clinical record for Resident #002 indicated that his/her medical diagnoses included dementia, pulmonary & heart disease and hearing loss. On the resident's most recent RAI-MDS 2.0 assessment, the resident's cognitive skills for daily decision-making was assessed as moderately impaired with short and long term memory problem. The resident's primary mode of locomotion was a wheelchair.
On five different occasions at different times of the day, Resident #002 was observed by Inspector #545 sitting in his/her wheelchair in the TV room on the 3rd floor with a front closure seat belt with alarm, as well as a chair alarm. Resident #002 was unable to demonstrate that he/she could cognitively remove the seat belt, when asked on all five occasions, despite each time staff attempting to speak clearly, slowly and use a loud voice to translate instruction into Cantonese.
On specified dates:
-observed Staff #115 asking Resident #002 to remove seat belt. Resident did not comply with request.
-observed Staff #116 asking Resident #002 to remove seat belt. Resident did not comply with request. This staff member indicated they had been working at the home for three years and new the resident well.
-observed Staff #117 asking Resident #002 to remove seat belt; staff member indicated that Resident had dementia and did not understand the instruction.

-observed Staff #120 asking Resident #002 to remove seat belt; the staff member indicated that the resident did not understand the request, but that the resident was at risk for falls and that is why the resident had a seat belt with an alarm.
-observed Staff #119 asking Resident #002 to remove seat belt; Resident pulled on the seat belt making an attempt to remove but was unable to demonstrate that he/she was cognitively able to unbuckle it.
A review of the plan of care dated September 2, 2014 indicated that the Resident was at high risk for falls due to unsteady gait and compromised dynamic balance, and that he/she forgets to call for assistance related to poor judgement, poor limbs coordination and muscle weakness. Interventions documented on the plan of care included to ensure bed was in low position with brakes locked with floor mattress and ensure personal alarm were properly applied and to instruct the resident to request assistance for transfers.
In an interview, Staff #121 indicated that the seat belt alarm was used as a fall prevention intervention for Resident #002 and indicated that this information was available on a document titled: "List of Residents on Physical Restraint & PASD's - limit freedom of movement sheet" and left at the nursing station in a plastic sleeve accessible to all staff. Under Resident #002's name, it was documented that Resident could unbuckle seat belt by self and was at risk for falls, and that a safety check every 2 hours was required when Resident was in his wheelchair. Staff#121 indicated that because Resident #002's seat belt alarm was not considered a restraint or a Personal Assistance Services Device (PASD) - the monitoring every 2 hours is not required to be documented.
In an interview, Staff #122 indicated that, the Physiotherapist recommended that a seat belt with an alarm be used for Resident #002 after that resident had an incident of a fall. Staff #122 indicated that the seat belt alarm had not been considered a restraint because Resident #002 was observed on different occasions unbuckling the seat belt.
In an interview, the Director of Care indicated that the home defined a restraint as physical device or equipment that can restrict the resident's movement and that the resident cannot remove easily. She indicated that she was aware that staff used a seat belt alarm for Resident #002 for falls prevention and was made aware that the Resident had been unable to demonstrate removal of the seat belt when asked by different staff. She indicated that a seat belt assessment would be done today, the family would be notified and a physician order for a restraint and/or PASD would be done if the seat belt continued to be required for Resident #002.
The Home's Use of Least Physical Restraint, policy number: CIP-1-07 defines a physical restraint as "any physical device or equipment that can restrict the resident's movement and the resident cannot remove easily. A device is, therefore, considered a

restraint based on the effect of the device on the individual, regardless of the intent in using the device. All devices and interventions must, consequently, be assessed from the resident's perspective on how it affects function and freedom.
Therefore, the licensee did not ensure that the restraint by a physical device, in this case, a seat belt, was included in the plan of care for Resident #002. [s. 31. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except
(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or
O. Reg. 79/10, s. 110 (6); O. Reg. 363/11, s. 9.

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #011 was not physically restrained while in bed.

A review of the medical record indicated Resident #011 has a specified diagnosis.

A review of the care plan, indicated that Resident #011 had a risk of falls. No mention of bed rails padding could be found.

The care plan also indicated, the staff were to ensure a panel was put in between the split side rails to block the gaps at all times for safety. This intervention was taken off the care plan. At that time the resident was a risk for falls due to self transferring.

On a specified date, Resident #011's bed was observed with four split bed rails in an up position and a bed rail pad intended for a full rail system was in place on each side. As a result the middle portion of the bed that would normally be open was blocked. The only way out of the bed would be to climb over the bed rails or out the bottom of the bed over the foot board.

In an interview with Staff #105, it was indicated that the bed rail padding was used with the rails to discourage the resident from climbing out of bed. Staff #105 did not consider the bed rails and padding as a restraint despite the system being used to keep Resident #011 in bed.

In an interview with the DOC, the DOC did not consider the rails and padding as a restraint. [s. 110. (6) (a)]

2. The licensee has failed to ensure that Resident #009 was not physically restrained while in bed.

On a specified date, Resident #009's bed was observed with four split bed rails in an up position and a bed rail pad intended for a full rail system was in place on each side. As a result the middle portion of the bed that would normally be open was blocked. The only way out of the bed would be to climb over the bed rails or out the bottom of the bed over the foot board.

A review of the medical record indicated Resident #009 has a specified diagnosis.

A review of the care plan dated, indicated that Resident #009 has a risk of falls and self transferring. No mention of bed rails padding could be found.

In an interview with Staff #105, it was indicated that the bed rail padding was used with the rails to discourage the resident from climbing out of bed. Staff #105 did not consider the bed rails and padding as a restraint despite the system being used to keep Resident #09 in bed.

In an interview with the DOC, the DOC did not consider the rails and padding as a restraint. [s. 110. (6) (a)]

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 with understanding what a restrain is; with the use of restraints; and to develop appropriate strategies to decrease residents risk of falls from rising unassisted from bed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement

For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.

2. Vest or jacket restraints.

3. Any device with locks that can only be released by a separate device, such as a key or magnet.

4. Four point extremity restraints.

5. Any device used to restrain a resident to a commode or toilet.

6. Any device that cannot be immediately released by staff.

7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. On a specified date, four over the toilet commodes on the first floor of the home where observed to have seat belts attached to them. In room #104 and #116 separate black belts where found on two commode chairs. In room #108 and #109, two commode chairs with a manufacturer's seat belt attached where observed. No residents were observed in the commode chairs. [s. 112. 5.]

2. Staff #129 indicated in an interview that the family of Resident #022 request that a seat belt be used when the resident is on the commode.

Staff #134 indicated in an interview, that the Staff only use a seat belt on a commode for Resident # 022.

Staff #111 also, indicated in an interview, that the family of Resident #022 wants a seat belt when the resident is on the commode and have given verbal consent.

Staff # 130 indicated in an interview,that Resident #022 cannot always undo the seat belt on the commode. [s. 112. 5.]

3. In an interview, a family member of Resident #022 indicated that the staff use a seat belt when they put the resident on the commode at the bedside and on occasion if the staff are busy, they leave the resident unattended on the commode at the bedside with a seat belt on and an over the bed table pushed in front to the resident. The family member indicated that they have arrived for visits and found the resident set up like this. [s. 112. 5.]

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 with understanding what a prohibited restrain is and refraining from using them, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident equipment is kept clean and sanitary in the home.

On a specified date, the following observations were made:
- Resident #008's wheelchair had stained seat cushion, and head rest and Resident #009 was seated in a wheelchair with a very soiled head rest, brown matter was stuck on the headrest.
-Resident #002's wheelchair was soiled with dried brown matter on the seat cushion.
On a specified date, further observations were made:
- three resident wheelchairs on the second floor were very soiled with dried food matter, and debris on the seats, metal bars and wheels of their chairs
- two residents chairs on the third floor had dried food matter on their cushions
- four resident's on the fourth floor had dried food matter, stains, and dust and debris on their wheelchairs
- two resident's on the fifth floor had dried white matter on the sides of their chairs and seat cushions with food debris on the rails to the sides of the wheelbase of the chairs.

In an interview, Staff #127 indicated that the home's process is the same on every unit, that if nursing staff notice the resident’s equipment is soiled, the Personal Support Staff can wipe down the equipment quickly with a clean towel, and disinfectant spray. Staff # 127 also indicated that if a residents chair or cushion is heavily soiled, Personal Support Staff can leave a note for evening or night staff in the communication book to power wash the equipment.

In an interview, Staff #100 indicated that all units have access to this power washer for

resident equipment cleaning and a schedule of resident equipment cleaning is also established for every weekend during night shift for every floor as well. Staff #100 observed the resident wheelchairs with Inspector #547 on the fourth floor and indicated that they should have been washed for these residents as they were soiled.

In an interview, Staff # 122 observed the soiled wheelchairs located on the third, fourth and fifth floors and indicated that these resident wheelchairs were heavily soiled, and should have been cleaned or noted by staff in the communication book as per the home's resident equipment cleaning process.

After a review of the homes records, no evidence of communication could be found to advise evening or night staff that any wheelchairs needed cleaning outside of the existing cleaning schedule. [S. 15. (2) (a)]

2. The licensee has failed to ensure that Resident equipment is kept clean and sanitary in the home.

On a specified date, Inspector #547 made the following observations during stage one of the Resident Quality Inspections.Resident #008's wheelchair had stained seat cushion, and head rest and Resident #009 was seated in a wheelchair in the lounge watching television with very soiled head rest with brown matter stuck on.
On a specified date, Inspector #545 also noted Resident #002's wheelchair to be soiled with dried brown matter on the seat cushion.
On a specified date, Inspector #547 further observed three resident wheelchairs on the second floor to be very soiled with dried food matter, and debris on the seats, and metal bars and wheels of their chairs. Two residents chairs on the third floor, four resident's on the fourth floor, and two resident's on the fifth floor.
Inspector #547 interviewed Staff that the home's process is the same on every unit, that if nursing staff notice the residents equipment is soiled, the Personal Support Staff can wipe down the equipment quickly with a clean towel, and virox spray they keep in the tub rooms. Staff also indicated that if a residents chair or cushion is heavily soiled, Personal Support Staff can leave a note for evening or night staff to power wash in the fifth floor tub room in the communication book at the nursing stations.Staff indicated that all units have access to this power washer for resident equipment cleaning.
Inspector #547 conducted record review of the communication books on every unit, and requested staff on every unit to translate the writing for the last month, and no indications regarding any of the soiled wheelchairs were left for evening or night staff

to clean on any unit.
Inspector #547 interviewed the ADOC, who observed the soiled wheelchairs located on the third, fourth and fifth floors and indicated that these resident wheelchairs were heavily soiled, and should have been cleaned or noted by staff in the communication book as per the home's resident equipment cleaning process. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 60 (2) in that the licensee did not ensure that the home responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Upon review of the Family Council minutes the following concerns were raised at three different meetings over the past year:

During a meeting on a specified date:
1) dissatisfaction concern regarding services provided by Mandarin speaking staff.
2) Parking space for visitors is still a problem at the Centre. No solution as of yet.
3) Wheelchair access ramp at one of the doors to garden was raised
4) Family Council mail box issue was discussed. There was a suggestion to have one main mail box instead of one on each floor. Pending for further discussion
5) A floor representative noticed that support staff on the floor are really busy and it was suggested that management look into adding more support staff to reduce the level of work.

On a specified date:
1) One family member complained that no one changed the incontinent product of a resident when it was soiled and the resident had to wait for up to 3 to 5 hours for it to be changed. When the family member requested assistance, the attitude of the staff was not helpful and friendly.

On a specified date:
1) A family member complained that their parent was not clean thoroughly, and reported that the bathing was sometimes done by other helpers not the nurses. The Chair replied that bathing was done by the PSW and not the nurses.

During an interview with the secretary of the Family Council, they indicated that they were elected as secretary of the Family Council early in 2014 and had attended three meetings. They indicated that the Executive Director, when invited and presented with concerns, usually responded verbally during the meeting. The Secretary indicated that they had not seen a response in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

During an interview with the Director of Care, covering for the Executive Director who was not available during the inspection, the DOC indicated that the home had investigated the complaint received a meeting but that a response in writing within 10 days of receiving this or other Family Council advice to concerns or recommendations could not found. [s. 60. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 110 (7) 1 in that the home did not ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for addressing incidents of lingering offensive odours.

The home's Preventive Maintenance policy: Odour Control Policy Number: CFM-III-05 indicates that "washroom floor is cleaned daily, and all fixtures in washrooms are cleaned and disinfected daily. If odour is noticed, more thorough cleaning is carried out and might involve using a stronger chemical."

In reviewing the Resident Room Cleaning Record, it was documented that Housekeeping staff had cleaned the room daily from a specified date, the last time on a specified date by staff #104.
Upon review of the Daily Deep Cleaning for Resident Room and Public Area, it was documented that Room #216 had received a "deep clean" on a specified.

On specified date, Inspector #545 observed an offensive lingering odour in the hallway when coming out of room 219. When inspector #545 walked into room #216, the inspector observed a Contact Precaution sign on the door with a Personal Protective Equipment caddie hanging on the wall, including a soiled cart by the door.

On a specified date, Inspector #545 observed again an offensive lingering odour outside of room #216. When entered the shared bathroom of room #216, the odour was more prevalent.

The DOC, the ADRC #130 and the Facility Manager entered room #216 with Inspector #545 and confirmed the observation of an offensive lingering odour. The environmental manager indicated that the bathroom was renovated on a specified date. Tiles under the bathroom sink and the walls under the sink were changed as Resident #018 in room #216 had socially inappropriate behaviour. The Facility Manager indicated that the odour eliminator and neutralizer products, including vinegar were used daily to clean the room to help manage the lingering offensives odour in room #216, but that it was not effective.

On a specified date—Inspector #545 observed Housekeeping Aide #104 and ARDC #130 in room #216 cleaning the room. A lingering offensive odour was observed. Housekeeping Aide indicated she had cleaned the stains with Vim Cream, and then washed the floors in the bedroom and bathroom with Stride Sc, Neutral Cleaner by

Diversey to help eliminate the lingering offensive odour, but indicated it was difficult to manage due to Resident’s socially inappropriate behaviour. Later, the Facility Manager pulled out a bottle of pink product: BreakDown - Odour Eliminator from the Housekeeping caddy and asked Housekeeping Aide #104 in front of Inspector #545 if she used the product daily, she indicated she did and proceeded to pour the product on the floor in Room #216 and then using a mop, wiped it down.

The Facility Manager indicated in an interview that Housekeeping Aide #104 reported a smell in room #216, and later reviewed the completed "Facility Department Monthly Environmental and Infection Control Audit, Appendix D" completed by this staff #104 on a specified date. He later indicated that he contacted a contractor to assess and provide a quotation for the renovation of room #216 to help manage lingering offensive odor; he added that no documentation was available to demonstrate consult requested. [s. 87. (2) (d)]

Issued on this 23 day of February 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : ANGELE ALBERT-RITCHIE (545) - (A1)

Inspection No. / No de l'inspection : 2014_328571_0027 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001105-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 23, 2015;(A1)

Licensee / Titulaire de permis :
YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE, SCARBOROUGH, ON, M1V-5L3

LTC Home / Foyer de SLD :
YEE HONG CENTRE - SCARBOROUGH McNICOLL
2311 McNICOLL AVENUE, SCARBOROUGH, ON, M1V-5L3

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8	Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Teresa Ku

To YEE HONG CENTRE FOR GERIATRIC CARE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

(A1)
The licensee will ensure that the resident accessible doors beside the nursing stations leading to non-resident corridors on floors 2,3 and 4 are equipped with locks and remain closed and locked at all times when they are not being supervised by staff.

The licensee will implement measures to ensure resident safety until such time as compliance with O. Reg. 79 10, s. 9 (1) is achieved.

Grounds / Motifs :

1. During the RQI, resident accessible doors leading to non-residential corridors were observed beside the nursing stations on floors 2, 3, and 4. These non-residential corridors contains a housekeeping closet and a service elevator.
In separate interviews, the DOC and Staff # 105 indicated that the doors to these non -residential hallways on floors 2,3 and 4 are not locked at any time nor are they constantly supervised.
In addition to potentially having unsupervised access to non-residential areas, a resident could also exit the home via the non-residential area.

(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

May 29, 2015(A1)

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee will ensure that the two main elevators of the home are equipped to restrict unsupervised resident access to the basement which contains non-resident areas and unlocked doors to the outside and to the ground floor which also contains unlocked doors to the outside.

Grounds / Motifs :

1. Throughout the RQI inspection, it was observed that it was possible for a Resident to access the two main elevators on the 2nd, 3rd and 4th floor by activating the elevator button. Once on the elevator, the resident cannot access floors 2-5 without a swipe card, fob or code. However, the resident could activate the ground floor and leave the nursing home via several unlocked doors. Or, the resident could activate the basement button and enter the basement which contains non-residential areas and unlocked doors to the outside. (571)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :

Feb 27, 2015

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

The home shall reassess all resident's that utilize a physical device or equipment that restricts their movement to:
1. Determine if the device or equipment has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release the device or themselves from the equipment; and
2. Ensure that the restraining of the resident is included in the resident's plan of care.

Grounds / Motifs :

1. A review of the clinical record for Resident #002 indicated specified medical. On the resident's most recent RAI-MDS 2.0 assessment, the resident's cognitive skills for daily decision-making were assessed as moderately impaired with short and long term memory problem. The resident's primary mode of locomotion was a wheelchair.

On five different occasions at different times of the day, Resident #002 was observed by Inspector #545 sitting in his/her wheelchair in the TV room on the 3rd floor with a front closure seat belt with alarm, as well as a chair alarm. Resident #002 was unable to demonstrate that he/she could cognitively remove the seat belt, when asked on all five occasions, despite each time staff attempting to speak clearly, slowly and use a loud voice to translate instruction to Cantonese.
On several specified dates:
-observed Staff #115 asking Resident #002 to remove seat belt. Resident did not comply with request.
-observed Staff #116 asking Resident #002 to remove seat belt. Resident did not comply with request. This staff member indicated she knew Resident well, had been working at the home for three years.
-observed Staff #117 asking Resident #002 to remove seat belt; staff member

indicated that Resident had dementia and did not understand the instruction.
-observed Staff #120 asking Resident #002 to remove seat belt; the staff member indicated that the resident did not understand the request, but that the resident was at risk for falls and that's why the resident had a seat belt with an alarm.
-observed Staff #119 asking Resident #002 to remove seat belt; Resident pulled on the seat belt making an attempt to remove but was unable to demonstrate that he/she was cognitively able to unbuckle it.
A review of the plan of care indicated that Resident was at high risk for falls due to unsteady gait and compromised dynamic balance, and that he/she forgets to call for assistance related to limitatins. Interventions documented on the plan of care included to ensure bed was in low position with brakes locked with floor mattress and ensure personal alarm were properly applied and to instruct the resident to request assistance for transfers.
In an interview on a specified date, Staff #121 indicated that the seat belt alarm was used as a fall prevention intervention for Resident #002 and indicated that this information was available on a document titled: "List of Residents on Physical Restraint & PASD's - limit freedom of movement sheet" and left at the nursing station in a plastic sleeve accessible to all staff. Under Resident #002's name, it was documented that Resident could unbuckle seat belt by self and was at risk for falls, and that a safety check every 2 hours was required when Resident was in wheelchair . Staff#121 indicated that because Resident #002's seat belt alarm was not considered a restraint or a Personal Assistance Services Device (PASD) - the monitoring every 2 hours is not required to be documented.
In an interview, Staff #122 indicated, the Physiotherapist recommended that a seat belt with an alarm be used for Resident #002 after that resident had an incident of a fall. Staff #122 indicated that the seat belt alarm had not been considered a restraint because Resident #002 was observed on different occasions unbuckling the seat belt.
In an interview, the Director of Care indicated that the home defined a restraint as physical device or equipment that can restrict the resident's movement and that the resident cannot remove easily. She indicated that she was aware that staff used a seat belt alarm for Resident #002 for falls prevention and was made aware that the Resident had been unable to demonstrate removal of the seat belt when asked by different staff. She indicated that a seat belt assessment would be done today, the family would be notified and a physician order for a restraint and/or PASD would be done if the seat belt continued to be required for Resident #002.
The Home's Use of Least Physical Restraint, policy number: CIP-1-07 defines a physical restraint as "any physical device or equipment that can restrict the resident's

movement and the resident cannot remove easily. A device is, therefore, considered a restraint based on the effect of the device on the individual, regardless of the intent in using the device. All devices and interventions must, consequently, be assessed from the resident's perspective on how it affects function and freedom.
Therefore, the licensee did not ensure that the restraint by a physical device, in this case, a seat belt, was included in the plan of care for Resident #002.
(545)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :

Dec 12, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L’APPEL

PRENDRE AVIS

En vertu de l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l’ordre ou les ordres qu’il a donné et d’en suspendre l’exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l’adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l’amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l’envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l’envoi. Si le titulaire de permis ne reçoit pas d’avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l’ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l’expiration du délai de 28 jours.

En vertu de l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d’interjeter appel, auprès de la Commission d’appel et de révision des services de santé, de la décision rendue par le directeur au sujet d’une demande de réexamen d’un ordre ou d’ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l’avis de décision du directeur, faire parvenir un avis d’appel écrit aux deux endroits suivants :

À l’attention du registraire
Commission d’appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l’amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d’appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d’appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23 day of February 2015 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : ANGELE ALBERT-RITCHIE - (A1)

Service Area Office / Bureau régional de services : Toronto