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
Jan 24, 2017	2016_484646_0010	032977-16	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

IVY LAM (646), TILDA HUI (512)

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): November 23, 24, 25, 28, 29, 30, and December 1, 2016.

The following inspections were completed concurrently during this Resident Quality Inspection (RQI): Critical Incident Inspection: Log #003101-15, related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Assistant Directors of Resident Care (ADRC), Activation Manager, Activation Worker, Social Worker, Environmental Services Manager, Housekeeping Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Council Chair, Residents' Council Chair, Residents, and Substitute Decision-Makers (SDM).

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes, and review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 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.

During stage one of the Resident Quality Inspection (RQI), resident #004 was triggered related to his/her incontinence from the most recent Minimum Data Set (MDS).

Review of the resident's current written plan of care and kardex for his/her bladder incontinence focus revealed an intervention was to use an identified type of incontinence product during the day, and a second identified type of incontinence product in the night

time. Another intervention in the same focus revealed that staff members were to ensure the second identified type of incontinence product of a specific size was used. Under the bowel incontinence focus, the intervention revealed that staff members were to ensure the second identified type of incontinence product was used.

Interview with resident #004 revealed that he/she has been using only the second identified type of incontinence product for a specified period of time. Interview with PSW #103 revealed that resident only used the second type of identified incontinence product. Interview with RPN #104 revealed that resident #004 uses a the first type of identified incontinence product during the day, but uses the second identified type of incontinence product at night. Interview with RN #109 revealed that he/she was unsure if the resident still wore the first identified type of incontinence product during the day or the second identified type of incontinence product only. RN #109 asked staff members and later clarified that the resident only wears the second identified type of incontinence product now, and that the resident's written plan of care needed to be clarified with this change.

Interview with ADRC #113 confirmed that resident's written plan of care regarding continence care lacked clear direction.

2. The licensee has failed to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

This inspection was triggered at stage one of the RQI indicated resident #001 was low risk for incontinence was identified as incontinent in the most recent assessment.

Review of resident #001's current care plan dated on a specified date in October 2016, identified the resident as occasional incontinent for bowel and incontinent for bladder continence. Review of the resident's MDS assessment on a specified date in October 2016, described the resident's bowel status as continent and bladder status as frequently incontinent. Review of the resident's Bladder and Bowel Continence Assessment on a specified date in July 2016, identified the resident's bowel continence level as incontinent, and bladder level as occasional incontinence.

Interview with PSW #117 and RPN #116 described the resident's bladder continence status as occasionally incontinent, and bowel status as usually continent. Interview with the DRC confirmed that there was a lack of collaboration among the nursing staff in the continence level assessment of the resident.

3. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

During stage one of the RQI, resident #003 was triggered related to incontinence from the most recent MDS. Review of resident #003's current written plan of care and kardex revealed that resident wears an identified size of an identified incontinence product for skin protection. Interviews with PSW #105, #108, and RN #106 revealed that resident has currently wears a different size of the identified incontinence product.

Interviews with PSW #105 and #108 further revealed that resident has changed to use the different size of the identified incontinence product for a better fit, and this change has been made for a few months. Interview with RN #106 further revealed that this change in the identified incontinence product size was not updated in resident #003's written plan of care. Interview with ADRC #113 confirmed that resident's written plan of care plan was not updated when his/her incontinence product needs changed.

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

This inspection was initiated as triggered during stage one of the RQI. Resident #002 was identified as having multiple areas of altered skin integrity during both the staff interview and census record review.

Review of resident #002's current written plan of care on a specified date revealed the resident experienced alterations to skin integrity. Further review of the resident's written plan of care revealed focus, goal, and interventions were set up to manage the resident's altered skin integrity.

Review of the resident's wound assessment conducted on a specified date on November 2016, revealed the resident has alterations to skin integrity. The resident's alterations to skin integrity were identified at a specified onset date. However, review of the resident's current written plan of care did not reveal any focus, goal, and interventions set up to address the issue of the newly acquired alterations to skin integrity.

Interview with PSW #122 verified that the resident's alterations to skin integrity at the specified parts of the resident's body were new. The PSW stated that he/she was

informed by the registered nursing staff not to get the resident up in the wheelchair for the past week to allow the alterations to skin integrity to heal. The PSW stated that the resident's skin in the multiple identified areas of the resident's body appeared slightly better. Interview with RPN #111 was surprised to note that there were no focus, goal and interventions established to manage the resident's newly acquired alterations to skin integrity.

Interview with the ADRC who was the skin and wound lead confirmed that strategies were expected to be set up in the resident's written plan of care to manage alterations to skin integrity.

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, and that staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, 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. 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was triggered at stage one when resident #002 was identified as having alterations to his/her skin integrity.

Review of resident #002's wound assessments revealed the resident experienced staged alterations to skin integrity. Further review of the resident's list of wound assessment revealed that an assessment was not conducted on the resident between a specified period in June 2016.

Interviews with RPN #111 and the ADOC who was the skin and wound program lead revealed that wound assessment was not conducted on the resident weekly between a specified period in June 2016. Interview with the DOC confirmed that weekly wound assessments were expected to be conducted on residents with alterations to skin integrity.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

This inspection was conducted as a result of observations completed during stage one of the RQI relating to resident home areas.

On a specified date in November 2016, inspector #646 observed a full and unlabeled bottle of an identified chemical, and a labeled spray bottle of another identified chemical in resident #007's shared washroom. Interview with resident #007 confirmed that the identified chemical products belonged to him/her.

Interview with PSW #100, revealed that the items belonged to resident #007, who liked to wash and sanitize his/her personal items. PSW #100 further revealed that these chemicals are not safe for residents and should not be stored in the residents' washroom. Interview with PSW #105, RPN #104, RN #106, revealed that the chemicals should not have been kept in residents' rooms. RN #106 further revealed that these products may pose a risk to other residents who wander into resident #007's room or washroom, and may take the above mentioned products. Interview with DRC confirmed that the hazardous substances were not kept inaccessible to resident #007.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Observation made on a specified date in November 2016 in a specified resident's room revealed that unlabeled personal care equipment including one used hair brush and a denture cup in a shared residents' washroom.

Interview with PSW #102 stated the labels must have worn off as they were put on by using a marker. The PSW stated he/ she will see to it that they are labeled. Interview with the DRC confirmed the home's expectation was for residents' personal care equipment to be labeled especially in shared washrooms.

Issued on this 31st day of January, 2017

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

Original report signed by the inspector.