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

Central East District
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Original Public Report

Report Issue Date: May 21, 2024	
Inspection Number: 2024-1291-0001	
Inspection Type: Critical Incident	
Licensee: Yee Hong Centre for Geriatric Care	
Long Term Care Home and City: Yee Hong Centre - Scarborough McNicoll, Scarborough	
Lead Inspector Rodolfo Ramon (704757)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18, 19, 23, 24, 25, 2024

The following intake(s) were inspected:

- Intake: #00091522/CI #2801-000004-23 - was related to the unexpected death of a resident.
- Intake: #00105692/CI #2801-000001-24, Intake: #00106128/CI #2801-000002-24 - were related to an infectious disease outbreak.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to the Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee has failed to ensure that staff performed hand hygiene at the moments required.

Rationale and Summary
According to 9.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices were

followed in the IPAC program and at a minimum, included hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During the inspector's observations, Personal Support Worker (PSW) #101 was observed assisting residents in a group activity. PSW #101 touched the hands of multiple residents and fed beverages to two residents without performing hand hygiene between contact with the residents. PSW #101 acknowledged that hand hygiene should have been performed between contact with each resident.

The IPAC lead confirmed that the PSW was required to perform hand hygiene between residents.

The PSW's failure to perform hand hygiene between residents placed residents at risk of contracting infectious diseases.

Sources: Resident observations, interviews with the PSW #101 and the IPAC lead. [704757]