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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Feb 5, 2016	2016_235507_0001	036192-15	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 FINCH
60 Scottfield Drive SCARBOROUGH ON M1S 5T7

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

STELLA NG (507), JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

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): January 4, 5, 6, 7, 8, 11, 12, 13, 14 and 15, 2016.

The following Complaint Intake was inspected concurrently with this Resident Quality Inspection: 033888-15.
The following Critical Incident System Intakes were inspected concurrently with this Resident Quality Inspection: 009898-14, 030424-15 and 033338-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Administrative Assistant (AA), Acting Director of Resident Care (Acting DORC), Assistant Directors of Resident Care (Ass. DORC), Food Service Manager (FSM), Food Service Supervisors (FSSs), Dietary Aide (DA), Registered Dietitians (RDs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Staff (AS), Cooks, Social Worker (SW), Facility Manager (FM), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' right to participate in the Residents' Council was fully respected and promoted.

Interview with resident #009 revealed he/she has not been invited to attend the Residents' Council meeting since admission.

Review of the Resident's Council term of references revealed every resident becomes a member of the Residents' Council immediately upon admission to the home; every member of the Council has the opportunity to participate in all meetings if he/she elects to do so.

Review of the Residents' Council meeting minutes binder for an identified year revealed the Residents' Council meetings took place four times. All residents were not invited to attend three of the four meetings, except two representatives from each floor.

Interviews with staff #119 and #123 confirmed the quarterly Residents' Council was open to the representatives from each floor only. [s. 3. (1) 20.]

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 the residents' right to participate in the Residents' Council is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #058 was protected from sexual abuse by

resident #008.

In accordance with the definition identified in subsection 2(1) of the Act, sexual abuse includes any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

a) Review of the progress notes of resident #058 and interview with staff #119 revealed that the resident required cues or supervision due to poor decision-making skills.

b) Review of the progress notes of resident #008, monthly monitoring schedule and interviews with staff #116, #119, #120 and #121 revealed the following:
- The resident exhibited responsive behaviours since admission. The resident started exhibiting inappropriate sexual behaviours towards resident #058 six weeks after admission. The inappropriate sexual behaviours included touching resident #058's legs, head and face.
- The resident was placed on Dementia Observation System (DOS) 24 hours/ day for a period of four weeks after the first inappropriate touching incident. The resident was also placed on one on one monitoring for the following six days. Resident #008 did not exhibit any inappropriate touching behaviours towards resident #058 while under one on one monitoring. Therefore, the one on one monitoring was discontinued after one week.
- The resident was referred to external resources for inappropriate body touch to other resident.
- Enviromental interventions were implemented in alerting staff when resident #008 left his/her room or someone entered resident #058's room. However, resident #008 was able to remove the enviromental interventions.
- Resident #008 was placed on isolation and remained in his/her room for most of the following month. DOS was discontinued during the isolation period.
- On an identified date, resident #008 was observed entering resident #058's room five times during the night.
- Staff were assigned to spend more time with resident #058 between care.
- Four days later, resident #008 was observed by a visitor touching resident #058's body in the TV lounge. When resident #008 was approached by staff and reminded him/her that inappropriate touching another person's body was not acceptable, the resident indicated he/she touched resident #058's head.

Interview with resident #008 revealed that he/she did not remember touching resident #058's body on the above identified date. Resident #008 further revealed that if resident

#058 indicated that he/she touched his/her body, then he/she must have done so.

Interviews with staff #121 and #123 confirmed resident #008 inappropriately touched resident #058 when his/her whereabouts were not monitored. [s. 19. (1)]

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 all residents are protected from sexual abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaints that have been received concerning the care of a resident was immediately forwarded to the Director.

Record review of an identified critical incident report (CIR), revealed a written complaint was sent to the DRC on an identified date via email regarding concerns in relation to the care of resident #021. Further review of the CIR revealed the written complaint was reported to the Ministry six days later.

Interview with staff #123 confirmed that the home did not have a written or verbal record that the above mentioned written complaint related to care of resident #021 had been immediately reported to the Ministry as required. [s. 22. (1)]

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 any written complaints that have been received concerning the care of a resident is immediately forwarded to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing was provided to the Residents' Council within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

Review of the Residents' Council meeting minutes for two identified dates indicated concerns and suggestions were made during the above mentioned meetings regarding different aspects of resident's care and services including cleaning of wheelchair, cancellation of resident's medication, privacy curtain, personal hygiene and resident's behaviour.

Review of the Concerns/ Suggestions and interview with staff #123 confirmed a detail response addressing each concern was given to the Residents' Council on two identified dates, which were 21 and 27 days respectively after receiving the concerns/suggestions from the Residents' Council. [s. 57. (2)]

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 a response in writing is provided to the Residents' Council within 10 days of receiving the Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On an identified date, during the lunch meal service in an identified dining room, the inspector observed residents #042, #043, #044 and #045 were served entrée while they were having soup. Interview with staff #100 revealed that serving residents with entrée and soup at the same time was included in the home's policy, but not indicated in the diet sheet or individual resident's plan of care.

On the same day, the inspector also observed resident #041 was served dessert while he/she was having entrée. Interview with staff #134 revealed that he/she knew the resident well and it was the resident's preferences to have dessert served while having entrée.

Review of the plan of care for residents #042, #043, #044 and #045 failed to reveal the above mentioned residents' preferences of having entrée served with soup. Review of the plan of care for resident #041 failed to reveal the resident's preference of having dessert served with entree.

Interview with staff #101 and review of plan of care for residents #041, #042, #043, #044 and #045 revealed that “resident prefers having soup with entrée and dessert before finishing entrée” was included in the residents’ plan of care on the same day after the inspector brought the concern to the home's attention. Staff #101 confirmed that the individual resident’s preferences of serving courses together should be indicated in the resident’s plan of care. [s. 6. (2)]

2. On three identified dates, the inspector observed resident #002 having an assistive device applied.

Interview with the resident, revealed he/she preferred having the assistive device applied and he/she was capable of removing it.

Review of the resident's plan of care with completion date of an identified date, failed to reveal the use of an assistive device.

Interviews with staff #128, #103 and #129 revealed that was the resident's preference to have the assistive device applied. Staff further indicated the resident was cognitive and capable of removing the assistive device as needed. Staff #103 and #109 confirmed the resident’s preference to have an assistive device applied was not included in the plan of care.

Interview with staff #115 confirmed the preference of the resident to have an assistive device should be included in the resident's plan of care. [s. 6. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between residents.

Review of the progress notes of resident #008 and interviews with staff #114, #115, #119 and #121 revealed that the resident exhibited responsive behaviours since admission.

Interview with resident #054 revealed that he/she was scared of a resident's responsive behaviours due to a specific incident. Resident #054 further revealed that he/she pushed an identified object against the door every night before going to bed since the above mentioned incident.

Interview with resident #042 revealed that he/she was aware of the above mentioned incident and he/she was nervous about that. Resident #042 further revealed he/she blocked the door at night before going to bed.

Interview with resident #041's family member revealed that resident #041 told him/her of an incident related to a resident's responsive behaviour.

Interview with resident #056's family member revealed that resident #056 did not sleep well at night because he/she was nervous of a resident's responsive behaviour.

Review of the progress notes of resident #008 and interviews with staff #115 and #121 revealed the resident had responsive behaviours, and interventions were implemented in relation to his/her responsive behaviours.

Interviews with staff #119, #121 and #123 revealed that they were aware of resident #008's responsive behaviours and residents #042 and #054 blocking the doors at night. However, they were not able to eliminate residents #042 and #054's fear entirely. [s. 55. (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the menu cycle was reviewed by the Residents' Council.

During the course of the inspection, observations of breakfast, lunch, morning and afternoon snack services on an identified unit revealed the home area is divided into two different cultural areas. Each cultural area is provided with a specific cultural menu cycle.

Review of the Residents' Council meeting minutes for an identified year, revealed one of the cultural specific Winter menu cycle was not reviewed by the Residents' Council.

Interview with staff #118 confirmed the above mentioned menu was not reviewed by the Residents' Council because residents resided in the identified home area were not represented in the Residents' Council for the past 12 months. [s. 71. (1) (f)]

2. The licensee failed to ensure that planned menu items were available and offered at each meal.

Review of the week-2 cultural specific Winter menu and the daily menu posted in the dining room for an identified date revealed oatmeal, turnip cake, toast, scrambled egg, dried baby oyster and congee were planned for breakfast for residents residing in an identified home area located on an identified unit.

Observation of the breakfast meal service on the identified date revealed fish, egg, salted red plums, rice, and soup were served to residents on regular and minced texture diets.

Interviews with staff #131, #130 and #118 confirmed residents residing on the identified home area who were on regular and minced texture diets were not offered the planned menu items as posted. [s. 71. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for production sheets for all menus.

Review of the week-2 cultural specific Winter menu for an identified date revealed a cultural specific breakfast that included Mackerel (fish), Tamagoyaki (egg) , Umeboshi (salted red plums), gohan (rice), and miso soup, was served.

Review of the production sheets binder failed to reveal the production sheet for the above cultural specific breakfast menu.

Interviews with staff # 131, #101 and #118 confirmed the production sheet for the above cultural specific breakfast menu was not available. [s. 72. (2) (c)]

2. The licensee failed to ensure that all food in the food production system were prepared using methods to preserve taste, nutritive value, appearance and food quality.

Observation of the lunch meal preparation on an identified date for one hour revealed low fat milk and all-purpose wheat flour were not used to prepare baked fish with white sauce and parsley as indicated in the home's standardized recipe.

Review of the Baked Fish with White Sauce & Parsley standardized recipe revealed the following ingredients are required: fish fillet, dried parsley, four litres of 1 per cent low fat milk, all-purpose wheat flour, table salt, white sugar, coconut milk and canola oil; and bake for one hour.

Interview with staff #132 revealed he/she used fish fillet, dried parsley, salt, canola oil, coconut milk; cream of mushroom to replace four litres of 1 per cent low fat milk and all-purpose wheat flour because the cream of mushroom contained milk and flour; and baked for 30 minutes.

Interview with staff #118 confirmed staff #132 did not prepare the fish according to the standardized recipe. [s. 72. (3) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Nutrition Manager worked on site in the capacity of Nutrition Manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

Record review of the home's license #2934-L01 dated July 1, 2010, revealed the home has 250 licensed beds. A review of the daily census revealed the occupancy of the home was over 97 per cent for two identified months. The minimum number of hours per week calculated under subsection (4) requires nutrition managers (NM) to work on site a minimum of 80 hours per week, based on 97 per cent or more occupancy.

Record review of the food services supervisor's (FSS) schedule for the above mentioned two months revealed the home provided the following FSS's hours per week:
- week 1 - 62 hours
- week 2 - 67.5 hours
- week 3 - 60 hours
- week 4 - 65 hours
- week 5 - 65 hours
- week 6 - 65 hours
- week 7 - 73 hours
- week 8 - 67.5 hours
- week 9 - 68 hours

Interview with staff #101 and #118 confirmed a short fall of 14.1 hours per week on average and a total of 127 hours for the above mentioned two months.

Interview with staff #123 confirmed the minimum number of hours for the FSM was not met during the above mention period. [s. 75. (3)]

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Issued on this 12th day of February, 2016

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

Original report signed by the inspector.