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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 6, 2019	2019_516734_0001	023946-17	Complaint

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

JADY NUGENT (734)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 18-26, 2019.

The following complaint was inspected:

Log #023946-17, related to skin integrity.

This inspection was completed concurrently with critical incident system inspection #2019_516734_0002.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care (DRC), Assistant Director(s) of Resident Care (ADRC), Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A Complaint (log #023946-17) was submitted to the Ministry of Health and Long Term Care on an identified date in 2017, related to an injury involving resident #001.

A review of resident #001's health care record indicated that there had been the discovery of an identified injury. Records also identified that resident #001 used an ambulation equipment for mobility, resulting in the required use of an identified device as a preventative measure.

Resident #001's progress notes documented that the resident's relative reported the use of an incorrect identified device in resident #001's ambulation equipment. Additionally, a note made by the Occupational Therapist (OT) #110 confirmed that an incorrect identified device was in use on the date of discovery.

During an interview with Occupational Therapist (OT) #110 they stated that everyone who uses a certain ambulation equipment should have an identified device to help with prevention and positioning, preventing skin breakdown; and the decision on the type of identified device depended on the need and physical function of the resident. Along with Inspector #734, OT #110 verified that resident #001 did not have the correct identified device in their ambulation equipment, on the date it was discovered by the family member. OT #110 also confirmed that there was a difference between the two identified devices, and the correct identified device that had been misplaced would have been the best for pressure relief.

During an interview with the home's Director of Resident Care (DRC) #111, Assistant Director of Resident Care (ADRC) #113 and ARDC #112 it was confirmed that the resident had been provided with the incorrect identified device for a period of time. DRC #111 was able to provide Inspector #734 with documentation that provided evidence that resident #001 had the incorrect identified device in their ambulation for a period of ten days. [s. 6. (7)]

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 that ensures the care set out in the plan of care for each resident is to be provided by staff, as specified in the plan, to be implemented voluntarily.

Issued on this 6th day of May, 2019

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

Original report signed by the inspector.