Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 22, 2021	2021_882760_0034 (A1)	008997-21, 009678-21, 011038-21	Critical Incident System

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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Clarification made related to the evidence produced in the inspection.

Issued on this 22nd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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Long-Term Care Home/Foyer de soins de longue durée

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60 Scottfield Drive Scarborough ON M1S 5T7

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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 15, 16, 17, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to a fall;

A log was related to a significant change in condition;

A follow up log to Compliance Order (CO) #001, LTCHA s. 19 (1), related to prevention of abuse and neglect, issued under inspection # 2021_823653_0012, on June 15, 2021, with a compliance date of July 27, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with the Nurse Practitioner (NP), the Physiotherapist (PT), Infection Prevention and Control Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Executive Director (ED), Assistant Directors of Resident Care (ADRC) and the Director of Resident Care (DRC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, reviewed home's air temperature monitoring logs, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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

3 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_823653_0012	760

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs.

The following observations were made during the inspection in the home:
- Four different visitors inside various resident rooms were seen without their mask on while in proximity of the resident.
- A PSW was seen sitting next to another staff member in a nursing station with improperly applied personal protective equipment (PPE). The DRC stated that staff are to have their PPE worn properly if they are sitting next to someone in the nursing station.
- Five staff members were observed exiting an elevator on the ground floor. The Executive Director (ED) stated that there should only be up to three people in an elevator at one time to maintain social distancing.
- A PSW was seen without proper PPE applied while they were serving lunch to residents in a dining room.
- An RPN was seen sitting in the nursing station without proper PPE applied. The RPN stated they should have their PPE applied properly when they were in the nursing station. The ED added that the area the RPN was sitting at was frequently used by other staff as well and therefore they should have their PPE properly applied at all times.

The observations demonstrated that that there were inconsistent Infection Prevention and Control (IPAC) practices from the staff and visitors of the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program and the measures set out in Directive #3, there could be possible transmission of infectious agents.

Sources: Directive #3, dated July 16, 2021; Interviews with the DRC, the ED and other staff; Observations made throughout the home on during the inspection. [s. 5.]

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 / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that hand hygiene agents were available at the point-of-care access for staff.

An observation demonstrated that there were no hand hygiene agents available for staff to use while they were distributing snacks to residents. A PSW stated they would be walking a distance to wash their hands at the sink to clean their soiled hands. Another PSW stated they would wash their hands at the sink if they were soiled, but would not perform hand hygiene in between giving residents their snacks, if they were not fed by the PSW. The DRC stated there should be hand sanitizing product placed on the snack carts for staff to perform hand hygiene in between distributing snacks to residents. DRC also clarified that the PSW would have needed to perform hand hygiene in between distributing snacks to the residents, even if they were not fed by the PSW. The lack of a hand hygiene agent readily available at the point-of-care may reduce the opportunities for the staff to perform hand hygiene.

Sources: Observations on resident units; Interviews with two PSWs and other staff. [s. 229. (9)]

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 in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #001 from Inspection #2021_823653_0012 served on June 15, 2021 with a compliance due date of July 27, 2021.

As per the compliance order, the home was to review the grounds of this compliance order and the home's expectation and relevant policies and procedures regarding a code blue - medical emergency with staff, including RPN #120.

RPN #120 did not recall being educated after the compliance order was issued to the home regarding the home's expectations and policies and procedures on a code blue medical emergency. The ED stated along with a review of the home's record showed that RPN #120 was not educated or trained on this required policy and procedure.

Sources: CO #001 from #2021_823653_0012; the home’s compliance action plan related to CO #001 from #2021_823653_0012; interviews with the RPN, ED and other staff. [s. 101. (3)]

Issued on this 22nd day of September, 2021 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JACK SHI (760) - (A1)
Inspection No. / No de l'inspection :	2021_882760_0034 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008997-21, 009678-21, 011038-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 22, 2021(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 Finch 60 Scottfield Drive, Scarborough, ON, M1S-5T7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lloyd del Rosario

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(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the home's universal masking policies and maintain social distancing in all areas of the home including but not limited to the elevators.

2. Provide on the spot education and training to staff and/or visitors not adhering with the universal masking policies or adhering with social distancing guidelines.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs.

The following observations were made during the inspection in the home:
- Four different visitors inside various resident rooms were seen without their mask

on while in proximity of the resident.
- A PSW was seen sitting next to another staff member in a nursing station with improperly applied personal protective equipment (PPE). The DRC stated that staff are to have their PPE worn properly if they are sitting next to someone in the nursing station.
- Five staff members were observed exiting an elevator on the ground floor. The Executive Director (ED) stated that there should only be up to three people in an elevator at one time to maintain social distancing.
- A PSW was seen without proper PPE applied while they were serving lunch to residents in a dining room.
- An RPN was seen sitting in the nursing station without proper PPE applied. The RPN stated they should have their PPE applied properly when they were in the nursing station. The ED added that the area the RPN was sitting at was frequently used by other staff as well and therefore they should have their PPE properly applied at all times.

The observations demonstrated that that there were inconsistent Infection Prevention and Control (IPAC) practices from the staff and visitors of the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program and the measures set out in Directive #3, there could be possible transmission of infectious agents.

Sources: Directive #3, dated July 16, 2021; Interviews with the DRC, the ED and other staff; Observations made throughout the home on during the inspection.

Severity: There was actual risk of harm to the residents because of the risk of transmitting infectious diseases when the staff and visitors are not adhering to the appropriate measures stated within Directive #3.

Scope: The scope of this non-compliance was widespread because the non-adherence to the measures stated within Directive #3 were identified from multiple observations conducted throughout the LTCH. The non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: In the last 36 months, the licensee was found to be non compliant with s. 5 of LTCHA, and one WN and one VPC, were issued to the home. (760)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 11, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of September, 2021 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JACK SHI (760) - (A1)

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Service Area Office / Bureau régional de services : Central East Service Area Office