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

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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
Feb 2, 2022	2022_595110_0001	015057-21, 019414-21, 001866-22	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

DIANE BROWN (110)

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): January 5, 6, 7, 10-13, 2022.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #015057-21 - Follow-up to CO#001 from inspection #2021_882760_0034 regarding s. 5. a safe and secure home.
Log #019414-21 related to a critical incident and falls prevention and management.
Log #01866-22 related to a critical incident and falls prevention and management.
Infection Prevention and Control (IPAC)

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Housekeeping Aide, Assistant Directors of Resident Care (ADRCs), Facility Manager and Executive Director.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices and audits, provision of resident care, staff to resident interactions, reviewed clinical health records, staffing schedules, RL solutions documents and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 VPC(s)
0 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. 5.	CO #001	2021_882760_0034	110

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 plan of care set out clear directions to staff and others who provide direct care to the resident.

A Critical Incident (CI) was submitted to the Ministry of Long -Term Care reporting resident #002's fall with resulting injury.

At the time of the resident's fall there were traces of incontinence on the floor along with the resident. A prior fall, there was also urine identified on the floor and the resident's brief and clothes were wet.

Night shift PSWs were separately interviewed and confirmed the resident's brief was changed on night shift, that staff did not toilet the resident. A PSW shared the night, of the most recent fall, the resident’s brief was changed prior to their fall, that the resident was awake and participated by holding the side rail while being changed. An interview with the night RPN shared the resident’s brief was changed on night shift as it was not safe to toilet the resident.

An interview with a full time day PSW stated resident #002 used the toilet with assistance and was on a scheduled toileting routine. The staff stated the resident always voided when toileted and it was not often that the resident was incontinent of urine or stool in

their brief. The PSW explained the resident did not communicate but followed simple instructions, and during the night staff would toilet them if they were awake.

A review of the toileting plan of care, in place at the time of the two identified falls, required staff to maintain an individualized toileting schedule over a 24 hour period including specifying times on night shift. The plan also provided direction to provide physical assistance by two staff to change resident's incontinent product on their bed.

A review of the post fall documentation relating to the resident's falls failed to identify the toileting and brief change discrepancy in the resident's plan of care.

An interview with ADOC stated that a toileting schedule was different than a brief change and that perhaps an appropriate alternative on nights would be the use of a urinal or commode and agreed to the lack of clear direction in the resident’s plan of care around the resident's toileting needs.

Sources: PSWs #108, #111, #113, RN #110 , ADOC #101, record review including progress notes, RL Summary notes, written plan of care. [s. 6. (1) (c)]

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

A CI was submitted the the Ministry of Long-Term Care reporting resident #001's fall resulting in a significant change of status.

Resident #001 had prior falls with no injury including a fall were staff found the resident sitting on the floor in their room. A later fall, the resident, without their mobility aid, stood unassisted, intended to walk and fell and a third fall when the resident was observed standing at their closet with their mobility aid and fell. The resident's plan of care required a one person assistance with transfers and mobility, along with a mobility aid, for safety as the resident had an unsteady gait and cognitive impairment.

Staff interviews revealed that the resident often ambulated around the unit independently with their mobility aid, describing them as they wandered around the unit. The staff shared they assisted the resident with transferring, by making sure a chair was placed behind them prior to them sitting or that their mobility aid was immediately in front as they stood up, as the resident was unsteady. An interview with the physiotherapist stated the resident had been refusing twice weekly physiotherapy treatments recommended to

reduce their risk of falling and confirmed the resident required extensive assistance from staff to ambulate in their room and corridor and for transfers.

At the time of the reported fall with injury, the resident was sitting in a chair in the unit nearby the nurses station. The RN shared they were in the nearby nurses station documenting and turned when they heard a sound and saw that the resident had left the chair, was walking with their mobility aid, lost their balance and fell.

A review of the post fall documentation relating to the resident's three prior falls failed to identify the lack of assistance, according to the plan of care, as a contributing factor. The resident's fourth fall with injury was related to the lack of assistance provided in transferring and mobility according to their plan of care.

Sources: Plan of care, physiotherapist post fall assessments, progress notes, RL Summaries, interviews with PSW #102, #103, PT #104. RPN #105, #107, RN #106, ADOC #100, #101, #114. [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 to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10, s. 49 (2) required the licensee to ensure that when a resident has fallen, the resident was assessed and, if required conduct a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of the homes' fall prevention policy failed to include reference to a clinically appropriate assessment instrument that is specifically designed for falls and when this instrument was required to be completed post-fall.

Registered staff interviews revealed that after a resident's fall they complete head to toe, skin, pain, head injury assessments, incident note and a fall risk assessment. The staff shared they also document in a 'RL solutions' template that included relevant information related to a fall. The template document was not part of the resident's health record and identified as a quality management tool within Yee Hong's corporate intranet. The RL solutions tool was not referenced in the home's Falls prevention and Management policy.

Sources: Policy #CIP-I-01 Falls Prevention and Management Program, dated August 2021, Achieva physiotherapy post fall assessment, point click care (PCC) pain assessment, head to toe assessment, skin problem assessment, Fall Risk Assessment - Morse Fall Scale, Head injury Routine, referrals, RPN #105, #107, RN #106, #110 and ADOC #100, #101 and #114. [s. 8. (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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

Issued on this 2nd day of March, 2022

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

Original report signed by the inspector.