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

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Original Public Report

Report Issue Date: October 4, 2023	
Inspection Number: 2023-1418-0002	
Inspection Type: Critical Incident	
Licensee: Yee Hong Centre for Geriatric Care	
Long Term Care Home and City: Yee Hong Centre - Scarborough Finch, Scarborough	
Lead Inspector Fatemeh Heydarimoghari (742649)	**Inspector Digital Signature** Fatemeh Heydarimoghari Digitally signed by Fatemeh Heydarimoghari Date: 2023.10.11 15:48:52 -04'00'
Additional Inspector(s) Miko Hawken (724)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5, 6, 7, 8, 2023

The following intake(s) were inspected:

- Two Intakes related to staff to resident abuse.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: LICENSEE MUST INVESTIGATE, RESPOND AND ACT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that every alleged, suspected, or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, was immediately investigated.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to alleged Personal Support Worker (PSW) #100 to resident abuse.

The Long Term Care Home (LTCH)'s investigation notes revealed that Registered Practical Nurse (RPN) #101 had received a complaint from PSWs #110 and #112 while caring for the resident. The resident had told them they had been physically, and verbally abused and neglected by PSW #100.

RPN #101 confirmed that they did not report the complaint to the supervisor immediately after receiving the complaint of the alleged abuse from a resident. Therefore, the incident was not investigated immediately by supervisors and PSW #100 continued to provide care for the resident for more shifts.

Assistant Director of Resident Care (ADRC) #102 confirmed that RPN #101 did not report the alleged abuse and, therefore there was a delay in investigating the alleged abuse.

Failing to report the alleged abuse immediately delayed the investigation and therefore placed the resident at risk of further potential abuse from PSW #100.

Sources: CIR, LTCH's investigation notes, Interviews with RPN #101 and ADRC #102. [724]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the resident's written plan of care provided clear direction to staff with regards to bathing.

Rationale and Summary

A CIR was submitted to the Director alleging verbal and physical abuse to the resident.

The resident's written care plan indicated the resident required assistance for bathing by one or two staff.

PSW #103 confirmed they provided a bath for the resident on their own. RPN #104 indicated resident required one person's assistance for bathing. The Director of Resident Care (DRC) acknowledged that the resident's plan of care lacked clear direction regarding assistance required during bathing.

Failing to ensure that the care plan provided clear direction to staff regarding bathing assistance placed resident at risk of unsafe bathing and not having their care needs met.

Sources: Resident's clinical records and interviews with DRC and staff. [742649]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that the resident was protected from physical and verbal abuse by PSW #109.

Rationale and Summary

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain. Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living unless the force used is excessive in the circumstances.

Section 2 of the Ontario Regulation 246/22 defines "verbal abuse" which means,

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety, where the resident making the communication understands and appreciates its consequences.

A CIR was submitted to the Director alleging verbal and physical abuse. The home's investigation notes indicated that PSW #109 admitted they talked loudly, and the resident felt scared when they saw PSW #109.

The resident's progress notes indicated they complained of pain due to being handled roughly by PSW #109 at the time of the incident.

The home's internal investigation notes identified colleagues who confirmed PSW #109 was sometimes rough with residents, and their mood was not stable. PSW #111 witnessed when PSW #109 suddenly became angry and talked loudly to the other residents when the resident did not follow their instructions well.

ADRC #102 confirmed the abuse was substantiated through the home's investigations.

Failing to protect a resident from abuse by staff #109 resulted in pain and a risk to the resident's safety and well-being.

Sources: CIR, Home's internal investigation note, and interview with ADRC #102. [742649]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

A CIR was submitted to the Director related to alleged PSW #100 to resident abuse.

The LTCH's "Zero Tolerance of Abuse" policy states:
Staff and volunteers at the Centre who witness or suspect the abuse of a resident, or who receive

complaints of abuse, shall report the matter immediately to the supervisor and/ or the Executive Director.

The LTCH's investigation notes revealed that RPN #101 had received a complaint from PSWs #110 and #112 while caring for a resident who told them, they had been physically, verbally abused, and neglected by PSW #100. The incident was not reported to ADRC #102 until a few days after this incident occurred.

RPN #101 confirmed that they did not report the complaint to the supervisor and/or the ADRC immediately after receiving the complaint of alleged abuse about the resident from PSWs #110 and #112.

Due to the delayed investigation of the incident, PSW #100 continued to work and cared for the resident for more shifts until ADRC #102 was informed of the incident. Therefore, there was an increased risk of further harm from PSW #100 to the resident.

Sources: CIR, Yee Hong Centre for Geriatric Care - Policy# CAD-VII-08 - Zero Tolerance of Abuse (LTC) - Last revised on August 2023, LTCHs investigation Notes, Interviews with PSW #110, RPN #101 and ADRC #102. [724]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (g)

The licensee failed to ensure the program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director under subsection (2) and the most current medical evidence.

Rationale and Summary

The home's Executor Director (ED) sent an email to staff, and families, advising them of a revised masking policy. The email titled, “YH Finch updates on masking effective August 2023, indicated that as of August 1, 2023, on residents' floors in LTC, masks are required. Everyone (staff, students, volunteers, families, and visitors) entering the residents' floors must wear a mask approved by Yee Hong”.

On a specific day, it was observed two contractors were standing in front of the elevator. One contractor had no mask on, and the other contractor had their mask tucked below the chin. A further observation found RPN #105 in the nursing station with their mask below their nose.

The ED stated the interpretation of the masking policy included the areas of the vestibule, as it was considered part of a resident's floor.

The LTCH's overall understanding of the masking policy was inconsistent.

RPN #105 stated that masking was mandatory on residents' floors in the home. Furthermore, the contractor acknowledged masking was not mandatory on the first floor and basement, but masking was mandatory on all other floors including the vestibules by the elevators.

The IPAC Manager acknowledged that the masking policy was not clear, and it should have specified the resident unit instead of the resident floor.

As there was confusion with the LTCH's revised masking memo on where and when to mask within the home, there was an increased risk of transmission of infectious diseases to residents and staff.

Sources: The home's update to the masking policy email titled, "YH Finch updates on masking effective August 2023", observations, and interviews with staff and management team. [742649]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee failed to ensure that the resident's substitute decision-maker is notified within 12 hours upon the licensee becoming aware of any alleged abuse or neglect of the resident.

Rationale and Summary
A CIR was submitted to the Director related to alleged PSW #100 to resident abuse.

The LTCHs, investigation notes revealed that RPN #101 had received a complaint from PSWs #110 and #112. The resident had told the PSWs, they had been physically, and verbally abused and neglected by PSW #100.

RPN #101 stated that they did not call the resident's POA upon learning of the alleged abuse by PSW #100. RPN #101 further stated the LTCH's expectation is that the POA should be called immediately upon the knowledge of any alleged abuse against a resident.

ADRC #102 confirmed that the POA was not informed in the required time frame due to RPN #102's delay in reporting to the supervisors and or the ADRC.

There was minimal risk and impact to the resident.

Sources: CIR, LTCHs investigations notes, Interviews with RPN #101 and ADRC #102. [724]