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

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: December 19, 2023
Inspection Number: 2023-1418-0003
Inspection Type: Complaint Critical Incident
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Scarborough Finch, Scarborough

Lead Inspector	**Inspector Digital Signature**
Natalie Jubian (000744)	Natalie Jubian Digitally signed by Natalie Jubian Date: 2023.12.20 15:15:29 -05'00'

Additional Inspector(s)
Najat Mahmoud (741773)
Miko Hawken (724)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4 to 8, 11, 12, and 14, 2023.

The inspection occurred offsite on the following date(s): December 11, 2023.

The following intake(s) were inspected:

- Intake related to alleged staff to resident neglect.
- Intake related to resident fall with injury.
- Intake related to a complaint regarding multiple resident care items.
- Intake related to injury of unknown cause.

- Intakes related to a complaint regarding multiple care items.
- Intake related to alleged resident physical abuse.
- Intake related to improper resident care.
- Intake related to incident resulting in transfer to hospital.
- Intake related to an unexpected resident death.

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

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report suspected abuse of a resident by anyone that resulted in a risk of harm to the resident to the Director.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director, detailing an alleged physical abuse incident between a resident and their family member.

The resident's clinical records indicated that the resident reported that their family member had allegedly tried to strangle them. This was reported to the Social Worker (SW) and the Director of Resident Care (DRC) a day before the incident was reported to the Director.

The SW confirmed the incident was reported to the DRC on the same day however, the incident was reported to the Director the next day.

Failing to immediately inform the Director of an alleged physical abuse incident posed no risk to the resident.

Sources: CIR, resident's clinical records, interview with SW. [724]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee failed to ensure that proper techniques to assist a resident with drinking fluids were utilized, including safe positioning.

Rationale and Summary

A CIR was submitted to the Director alleging an incident of improper care to a resident.

The CIR stated a resident was provided fluids while laying face up in bed when a staff member intervened. The resident's clinical records indicated the resident was found laying face up when a staff member fed them water. The resident's mouth was closed, and the top of their clothing was wet. The home's internal investigation notes and interview with Assistant Director of Resident Care (ADRC) #102 confirmed that the allegation of improper care was substantiated.

ADRC #102 acknowledged that when the staff member fed the resident fluids in a face up position, there was a risk of aspiration. ADRC #102 also stated that the expectation of staff is to ensure that the head of the bed is elevated to ensure safety of the resident.

Failing to ensure that the resident was positioned safely while providing them fluids placed the resident at risk of aspiration.

Sources: Long-Term Care Home's (LTCH) investigation notes, resident's clinical records, interview with ADRC #102. [741773]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the

resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to report to the director an incident that resulted in a significant change in a resident's health condition no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5).

Rationale and Summary

A CIR was submitted to the Director related to a resident's ingestion of their personal item and subsequent death.

The resident's clinical records showed they had no prior history of responsive behaviours or clinical indications that there was a risk of the resident ingesting foreign objects. It was noted by staff that the resident's personal item had gone missing and later that day the resident vomited once. The next day, the resident had vomited two more times and was seen by the Nurse Practitioner who ordered to send the resident to hospital. The resident was diagnosed with a condition and had a significant change in condition.

Assistant Director of Resident Care (ADRC) #102 confirmed that the incident was not reported to the Director within three business days after the occurrence of the incident.

Failing to inform the Director within three business days of this incident posed no risk to the resident.

Sources: CIR, resident's clinical records, interview with ADRC #102. [724]