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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: July 30, 2024
Original Report Issue Date: June 25, 2024
Inspection Number: 2024-1418-0002 (A2)
Inspection Type: Complaint Critical Incident
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Scarborough Finch, Scarborough

AMENDED INSPECTION SUMMARY

This report has been amended to:
-To correct the legislative reference in CO #002 to O. Reg 246/22 s. 12 (1) 3

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Lead Inspector Rodolfo Ramon (704757)	**Additional Inspector(s)** Maria Paola Pistritto (741736)
Amended By Rodolfo Ramon (704757)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
-To correct the legislative reference in CO #002 to O. Reg 246/22 s. 12 (1) 3

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6-10, 13-16, 2024

The following intake(s) were inspected:

- One Intake was related to a fall with injury
- One Intake was a complaint related to neglect, plan of care, bathing, and falls
- One Intake was related to alleged abuse
- One Intake was a complaint related to medication management
- One Intake was related to verbal abuse

The following intakes were completed: Two intakes were related to falls with injury

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care for a resident was documented.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director for a fall with injury. The

resident's care plan identified them as a high falls risk with close observation as a falls interventions. Another falls intervention was implemented related to continence.

There was no documented records of the intervention related to close observation. The Director of Care (DOC) confirmed that documentation of close observation could not be produced.

On the date of the resident's fall, the residents falls intervention related to continence care was not implemented.

Failure to implement and document the falls interventions put the resident at risk for injury.

Sources: Resident's plan of care and interview with staff. [741736]

WRITTEN NOTIFICATION: BATHING

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed more frequently as determined by their hygiene requirements.

Rationale and Summary

A complaint was received by the Director for concerns about bathing. The resident's family and power of attorney (POA) had requested the home to bathe the resident

more frequently during the week and was informed this could not be accommodated due to short staffing.

Associate Director of Resident Care (ADRC) #106 confirmed there was a time the home could not meet the needs of residents who wanted to be bathed more frequently due to staffing concerns. ADRC #106 has confirmed the home has hired new Personal Support Workers (PSWs) and moving forward the home would accommodate additional baths during the week for the resident.

Failure to accommodate additional baths from residents and family put resident rights at risk.

Sources: The resident's care plan and interview with staff. [741736]

WRITTEN NOTIFICATION: PERSONAL ITEMS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee has failed to ensure that a resident's personal belongings were labeled.

Rationale and Summary
During Infection Prevention and Control (IPAC) observations of the home, a personal item was observed without a label. When the inspector asked who the personal item belonged to, a Registered Practical Nurse (RPN) informed the inspector that

they belonged to a specific resident. A PSW also informed the inspector that the personal item was shared amongst residents.

ADRCs #105 and #106 confirmed that the personal item was required to be labeled. Failure to label the resident's personal belongings placed the residents at risk of contracting infectious diseases.

Sources: Observations, interviews with the PSW, RPN, ADRC #105, and ADRC #106. [704757]

WRITTEN NOTIFICATION: PERSONAL ITEMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (b)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(b) cleaned as required.

The licensee has failed to ensure that a resident's personal belongings were cleaned.

Rationale and Summary
During Infection Prevention and Control (IPAC) observations of the home, a personal item was observed without a label. When the inspector asked who the personal item belonged to, a Registered Practical Nurse (RPN) informed the inspector that they belonged to a specific resident. The inspector noted the personal item to be in unsanitary condition.

The RPN confirmed that the resident's personal item was not cleaned by the staff.

Failure to keep clean the resident's personal belongings placed the resident at risk of contracting infectious diseases.

Sources: Observations, interviews with the RPN. [704757]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's individualized plan for their continence care was implemented.

Rationale and Summary
A CIR was received by the Director for a fall with injury. The resident's care plan identified assistance with continence as a falls intervention.

On the day of this incident, the resident's clinical records indicated the resident did not receive the required assistance with continence care. The resident communicated to staff on the day of the fall that they required assistance with continence.

The ADRC confirmed that the resident did not receive the assistance required to meet their continence needs. The home's investigation notes found that PSW #112 did not complete a safety check for the resident prior to starting their shift as per the expectation.

Failure to implement the care plan interventions related to continence care contributed to the resident's fall incident.

Sources: The resident's plan of care and interview with staff. [741736]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

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:

5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that food and fluids being served at a temperature that is both safe and palatable to the residents.

Rationale and Summary

A complaint was received by the Director for concerns regarding the home heating outside food. Due to the resident's medical condition, the resident required outside food on a regular basis.

The care plan for the resident identified them as a high nutritional risk. The resident confirmed that staff did not heat up any outside food and was served cold. The ADRC confirmed that outside food was not heated for the resident prior to serving.

Failure to serve food at a palatable temperature for the resident put their nutritional status at risk.

Sources: The resident's care plan and interviews with staff. [741736]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Rationale and Summary
A complaint was received by the Director regarding food brought into the home. The inspector observed a resident sitting by themselves eating in their room. The Inspector observed the resident's plate contained large pieces of food that were not cut up.

The care plan for the resident identified supervision for eating and assisting for all meals. The PSW confirmed they were not in the room when the resident started eating as they were completing other tasks.

Failure to supervise and provide meal assistance for the resident put them at risk for choking injuries.

Sources: The resident's care plan, observations and interview with staff. [741736]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to the IPAC was implemented. Specifically, the licensee has failed to ensure that staff performed hand hygiene at the moments required.

Rationale and Summary

In accordance to 9.1 b) of the IPAC Standard for Long-Term Care Homes, revised September 2023, the licensee was required to ensure that Routine Practices were followed in the IPAC program and at a minimum, included hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During observations of the environmental cleaning and disinfection practices, a housekeeper was observed changing their gloves multiple times without doing hand hygiene between changes. The housekeeper acknowledged that when discarding and using a new pair of gloves, hand hygiene was required to be performed in between changes. The IPAC lead confirmed that in addition to the four moments of hand hygiene, hand hygiene was required to be done when removing and putting on new Personal Protective Equipment (PPE).

Failure to do hand hygiene when required placed the residents at risk of contracting infectious diseases

Sources: Observations, interviews with the housekeeper and the IPAC lead

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that the response provided to a person who made a complaint included confirmation that the licensee was required to immediately forward the complaint to the Director.

Rationale and Summary
The LTC home received a complaint regarding the care of a resident. A written response was sent to the complainant.

A review of the response sent to the complainant indicated the home did not provide confirmation that the licensee was required to immediately forward the complaint to the Director.

The ADRC who sent the response to the complainant verified that the response did not include confirmation that the licensee was required to immediately forward the complaint to the Director.

Failure to communicate to the complainant the requirement to forward the complaint to the Director resulted in lack of transparency during the complaint management process.

Sources: The home's complaint records, and interview with ADRC #105. [704757]

WRITTEN NOTIFICATION: CONSTRUCTION, RENOVATION, ETC. OF HOMES

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.
Construction, renovation, etc., of homes

s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee has failed to ensure that alterations were not made to the home without first receiving the approval of the Director.

Rationale and Summary
During observations of the home, a resident lounge was seen being used as a staff lunch room. The DOC stated that the rooms were called "small tv lounges", and confirmed that on all floors the lounges were resident spaces that were being used as staff lunch rooms.

The Administrator informed the inspector that originally, the staff lounges that were used before for staff breaks were reassigned for hospice which led the home to use the resident lounges as staff rooms without notifying the Director.

Failure to notify the Director when the resident spaces were altered reduced the available space for residents to use.

Sources: Observations, interviews with the DOC and the Administrator [704757]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
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:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:

1) The Director of Care (DOC), the Food Service Manager (FSM), or Assistant Directors of Care (ADRCs) are to establish and implement a process to communicate to staff residents #001 and #003's food and feeding preferences, specifically regarding food brought into the home from outside. The process should outline how the home will ensure that the residents' preferences and the process to accommodate their preference is accessible to all staff.

a) Educate all PSW staff working with residents #001 and #003 of the developed and implemented communication process regarding outside foods brought into the home

b) The FSM is to provide return demonstrations through case based scenarios regarding when food should and should not be thrown out. Keep a record of all staff requiring further educational support.

c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) Make this record available to the inspector immediately upon request.

2) For a period of one week, the home will implement a sign in sheet for staff who work with residents #003 and #001, where staff will confirm that they have reviewed the resident's dietary and feeding preference and the process put in place by the home. Keep documented records of the sign in sheets including the staff name and time of acknowledge. Make this record available upon the inspector' request.

Grounds

1) The licensee has failed to ensure that a process was implemented to ensure that staff assisting residents, were aware of their diets, special needs and preferences.

Rationale and Summary

The LTC home received a complaint from the resident's Substitute Decision Maker (SDM) regarding multiple areas of care including dietary concerns. The SDM requested that the resident be permitted to eat food with a specific consistency that was different to the one specified in the plan of care.

The resident's plan of care indicated that the resident's food was required to have a specific consistency due to nutritional risk and their medical diagnosis. The Registered Dietitian (RD) stated that the resident was at nutrition risk if the resident were to eat food with a different consistency. The RD also confirmed that the SDM was informed of the risk. The SDM acknowledged the risk and insisted on requesting that the resident be allowed to eat food provided from outside

ADRC #105 confirmed with the inspector that in order to respect the SDM's wishes, a process was implemented. During this process, the SDM would be allowed to bring food from outside and give it to the resident as long as a staff supervised the resident while eating. The process also required that the resident ate the food in an easily accessible area. The SDM agreed to this process.

A PSW acknowledged that the resident had nutrition risk and could not eat food with a different consistency to the one provided in the home. The PSW however, stated they were not aware that the home agreed to allow the resident's family to feed the resident food from outside.

When the inspector asked the ADRC how staff were made aware of this process, the ADRC stated a meeting was held with staff to inform them of the process. The meeting minutes were available for all staff to review before the start of their shift,

but the ADRC confirmed that the staff were not required to review any meeting minutes for meetings that took place more than two weeks prior to their shift. The ADRC verified that to become aware of the resident's preference, PSWs would have to review all the progress notes for the resident which the ADRC acknowledged was not the correct process.

Failure to implement a process to inform staff of the resident's dietary preference and agreed upon intervention with their SDM impacted the resident's quality of life.

Sources: The resident Care Plan, Progress Notes, Interviews with the PSW and ADRC. [704757]

2) The licensee has failed to ensure that the home has a dining and snack service that includes a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

Rationale and Summary
A complaint was received by the Director regarding concerns about outside food brought in for a resident, specifically the complaint was concerned that outside food brought in for the resident was being thrown out the same day and not stored in the designated fridge on the unit. Due to the resident's medical condition, the resident required outside food on a regular basis.

The care plan for the resident identified them as high nutritional risk. The family of the resident asked the home to put the food brought from outside and stored in the fridge as the resident did not eat large quantities. The PSW confirmed that if the resident declined to eat the food, the food would be thrown away.

The homes food policy supports outside food being brought in to support residents. The policy also suggested that left over food can be stored in the fridge for three to four days and the fridge will be checked nightly for expired or spoiled food.

Failure to store outside food for the resident in the designated fridge puts their nutritional status at risk and decreased nutritional intake.

Sources: observation, the resident's care plan and interview with PSW #104. [741736]

This order must be complied with by August 2, 2024

COMPLIANCE ORDER CO #002 Doors in a home

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Environmental Service Manager (ESM) is to develop and implement a process for keeping housekeeping doors closed on 2 South Resident Home Area (RHA).

a) The ESM will provide in person education to housekeeping staff on 2S RHA regarding the homes process for keeping housekeeping doors closed and locked.

b) ESM or management designate will conduct daily audits for three weeks on all shifts including holidays and weekends for closed and locked

housekeeping doors on 2S. Keep a documented record of the audits completed, who completed the audit, and audit completion date.

c) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

d) Make this record available to the inspector immediately upon request.

Grounds
The licensee has failed to ensure that areas or doors that residents do not have access to must be kept closed and locked.

Rationale and Summary
A complaint was received by the Director for concerns regarding showering. Inspector #741736 observed the housekeeping room on the specific RHA open with a door stopper. Inside the room, the inspector observed cleaning chemicals that were easily accessible. The RN confirmed that the housekeeping door should be closed and would provide support to the housekeeping staff.

Failure to keep doors closed and locked in areas not accessible to residents puts them at risk for injury.

Sources: Observation and interview with staff. [741736]

This order must be complied with by August 2, 2024

COMPLIANCE ORDER CO #003 INFECTION PREVENTION AND CONTROL

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program

s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Ensure that hand hygiene agent is available in every resident room in the home at the point-of-care.

2) Conduct audits three times a week for two weeks of three resident different resident rooms to ensure that hand hygiene agent is accessible at the point-of-care. The Audits shall be conducted by the IPAC lead. Keep a documented record of the audit date, time, results of the audit and action taken.

Grounds
The licensee has failed to ensure that the hand hygiene program included access to hand hygiene agents at point-of-care.

Rationale and Summary
During IPAC observations, the inspector noted an isolation room that had a sanitizer dispenser not in use at the bedside. Sanitizers at the bedside were also noted not to be in use in three resident rooms.

According to the IPAC lead and the DOC, there were concerns with falls risk as well as the cost associated with the sanitizer product leaking on to the floor at the bedside. Subsequently the LTC home received a recommendation from the IPAC Hub advisor at Scarborough Health Network (SHN) to remove the sanitizers at the point of care.

The IPAC hub advisor at SHN confirmed to have advised the LTC home to remove sanitizers at the point of care and acknowledged this direction should not have been provided to the home

Failure to provide hand hygiene agents at point-of-care prevented the staff from potentially being able to comply with the four moments of hand hygiene, placing residents at risk of contracting infectious diseases.

Sources: IPAC observations, Interviews with the IPAC hub advisor, the IPAC lead and the DOC. [704757]

This order must be complied with by August 2, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.