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

Public Report

Report Issue Date: January 22, 2025
Inspection Number: 2025-1418-0001
Inspection Type: Critical Incident Follow up
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Scarborough Finch, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21 and 22, 2025
The following intake(s) were inspected:

- Related to an outbreak.
- First Follow-up – Compliance Order (CO) #002/ 2024-1418-0003, related to O. Reg. 246/22 - s. 26 - Compliance with manufacturers' instructions, with Compliance Due Date (CDD) of January 20, 2025.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were closed:
Order #002 from Inspection #2024-1418-0003 related to O. Reg. 246/22, s. 26

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 Routine Practices and Additional Precautions were followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes September 2023" (IPAC Standard).

Specifically, the licensee failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal, and disposal, were followed in the IPAC program as required by Additional Requirement 9.1 Additional Precautions (f) under the IPAC Standard.

During an observation, a Personal Support Worker (PSW) was observed exiting a resident's room without a mask or face shield. After further clarification, the PSW indicated that due to lack of a receptacle within the vicinity, they had to dispose of their PPE in the resident's room. The PSW confirmed that no residents were in the room. The home failed to provide staff with the ability to appropriately dispose of PPE.

Sources: Observations and interview with IPAC Lead and Director of Resident Care.