Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 11, 2013	2013_270531_0004	000121-13, 000521-13	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

SUSAN DONNAN (531)

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): December 05 & 06, 2013.

During the course of the inspection, the inspector(s) spoke with two identified Residents, Personal Support Workers(PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Dietitians (RD), Assistant Directors of Resident Care (ADRC), Director of Resident Care (DORC), and the Executive Director (ED)

During the course of the inspection, the inspector(s) toured the home areas, reviewed Health Care records of identified Residents, observed meal service and medication administration, reviewed licensee policies "Nursing Responsibilities for Medication Reconciliation" CN-IX-02, "Promoting a Safe Medication Management System: Nursing Responsibilities" CNU-IX 01, "Regular Therapeutic Diets" CFS- II06 , "Promoting Nutrition:Nursing Responsibilities", CNU-V-02, Professional Advisory Committee Minutes (PAC), Internal medication incident reports, reviewed licensee's Quality Improvement Indicators related to Medication, and two Critical Incident Reports.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.131(1) when Resident #2 consumed pre poured drugs not prescribed for the resident.

On an identified date RN#1 pre poured medication and left them unattended in the resident's room.

Interviews with RN#1 and review of the internal incident report confirmed that Resident #2 consumed medications not prescribed for this resident.

Review of Resident #2 physician orders confirmed that the medications consumed were not prescribed for the resident. [s. 131. (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 by ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident., to be implemented voluntarily.

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Issued on this 11th day of December, 2013

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

Susan Donnan