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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2017	2017_484646_0002	001360-17	Resident Quality Inspection

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 - MARKHAM
2780 BUR OAK AVENUE MARKHAM ON L6B 1C9

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

IVY LAM (646), STELLA NG (507), TILDA HUI (512)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 17, 18, 19, 20, 23, 24, 25, and 26, 2017.

The following inspection was completed concurrently during this Resident Quality Inspection (RQI): Critical Incident Inspection: Log # 023863-16, related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the interim Executive Director (ED), Assistant Directors of Resident Care (ADRC), RAI Coordinator, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Family Council Chair, Residents' Council Chair, Residents, and Substitute Decision-Makers (SDM).

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes, dining room observations, and review of the home's staff training records, staff schedules, meeting minutes, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

a) Review of resident #005's current written plan of care revealed that the resident was to

be provided with three different identified assistive devices. Review of resident #005's kardex revealed that the kardex did not include one of the above-mentioned assistive devices.

Interview with PSW #101 revealed that he/she was not aware that resident #005 used the assistive device that was not included on the kardex, and was unable to find information regarding the device on the kardex. Interview with PSW #119 revealed that PSWs access the kardex on Point of Care (POC) as their primary source of information. Interview with RN #110 revealed that resident #005 did use the above-mentioned assistive device and the information was on the Point Click Care (PCC) written care plan, but for information to be shown on the kardex, the registered nursing staff would have to select 'kardex' for the intervention, and this was not done for the identified assistive device for resident #005.

Interview with ADRC #102 confirmed that resident #005's written care plan did not set out clear direction regarding the resident's interventions.

b) Review of resident #003's current written care plan on PCC revealed that he/she required an identified type of assistive device. Review of the PSW assignment sheet on two identified dates, posted on the nursing station revealed that resident had a different identified type of assistive device. Review of the kardex on POC for resident #003 revealed that information regarding the resident's type of assistive device was not included. The inspector's observations of resident #003's room revealed that he/she was provided an assistive device that was different than what was specified on the PSW assignment sheet.

Interviews with PSW #106 and #124, and RPN #123 revealed that interventions regarding resident #003's identified type of assistive device was not included in the kardex. PSW #124 and RPN #123 further revealed that the PSW assignment sheet was not accurate regarding resident #003's use of the identified assistive device.

Interview with ADRC #114 revealed that the information concerning resident #003's identified assistive device should have been included in the kardex and it was the home's expectation for the residents' PSW assignment sheet, POC kardex and written plans of care to be consistent. ADRC #114 confirmed that resident #003's written plan of care did not provide clear direction to staff.

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Review of resident #006's Resident Assessment Instrument – Mini Data Set (RAI-MDS) assessments on two identified dates, revealed that the resident did not require any mobility aid, during last seven days prior to the above mentioned assessments. Review of resident #006's Follow Up Question Report in regards to the resident's Activity Daily Living (ADL) – Locomotion on Unit, revealed that the resident required total assistance for four days and two days, respectively, during the above-mentioned periods.

Interview with PSW #112 revealed that resident #006 has been using the identified mobility device to move around on the unit for over a year, and the resident required another person to assist him/her with the identified mobility device. Interview with RPN #113 revealed that when the RAI-MDS assessment was being coded, registered staff were required to review the flow sheet completed by PSWs and consult PSWs for any discrepancies or condition changes. Staff #113 revealed that he/she did not remember whether the consultation with PSWs took place in regards to resident #006's use of the identified mobility device when the above mentioned RAI-MDS assessments were being completed.

Interviews with ADRC #114 and RAI Coordinator #115 revealed that registered staff were required to review the flow sheet completed by PSWs, clarify with PSWs for any discrepancies or condition changes when completing the RAI-MDS assessments. Staff #114 and #115 further revealed that if the resident required total assistance for locomotion on the unit, this meant the resident was using the identified type of mobility device. ADRC #114 confirmed that the registered staff did not collaborate with PSWs who provided care to resident #006 when completing the resident's above-mentioned RAI-MDS assessments.

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Review of resident #004's written plan of care for nutrition revealed that the resident was at high nutritional risk due to the resident not using an identified assistive eating device.

Review of resident's current written plan of care revealed that an intervention was to ensure resident #004's identified assistive eating device were in place.

Review of resident's progress notes on an identified date, revealed that the dietitian assessed the resident to have concerns related to not using the identified assistive eating device and the resident did not like an identified type of mechanically altered diet.

Interviews with PSW #103 and #116, and RPN #113 revealed that according to their knowledge, the resident should be using the identified assistive eating device at mealtimes. Interview with RPN #113 further revealed that he/she was not aware of the information from the resident's progress notes regarding that resident #004 no longer used the identified assistive eating device.

Interview with ADRC #114 confirmed that there was a lack of communication and collaboration between the dietary and nursing staff in the home in the development and implementation of different aspects of resident #004's written plan of care. Interview with the interim ED revealed that the home has acknowledged existing miscommunication between the dietary and nursing department, and had taken steps to address this.

4. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Review resident #002's most recent care plan on an identified date in 2017, revealed that the resident was at high risk of falls related to his/her cognitive impairment. One of the interventions was to conduct safety checks at an identified interval of time.

Interviews with PSW #111, and RPNs #104 and #115 revealed that most of the safety checks were conducted by PSWs, and registered staff would also conduct the safety check at times. Staff #104, #111 and #115 revealed that the safety check was conducted to identify the resident #002's location and to ensure the safety of the resident. Staff #104, #111 and #115 further revealed that they did not document the location of the resident or whether the resident was safe after each safety check.

Interview with ADRC #114 revealed that if the task of safety checks at the identified interval of time was not created in the POC, and there was no place for staff to document the safety check. Staff #114 confirmed that the hourly safety check for resident #002 was not documented.

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

a) Review of resident #003's falls incident notes in progress notes revealed that the resident had a fall on an identified date, and one of the follow-up actions included safety checks at an identified time interval. Further review of resident #003's fall incidents notes revealed resident had another fall on a separate identified date, and one of the follow-up actions was to provide safety checks for resident #003 at the same identified time interval.

Review of resident #003's current written plan of care on PCC and resident's kardex on POC revealed that the information specifying resident #003's safety check was not included. Review of resident's PSW assignment sheet for an identified period in 2017, revealed that resident's safety checks were to be done at a different identified time interval.

Interviews with PSW #124 and RPN #123 revealed that resident #003 was at high risk for falls, and his/her safety check was done at a time interval different than both the progress notes and the PSW assignment sheet. After review of resident #003's fall incident notes, RPN #123 revealed that the intervention regarding resident #003's safety check to be done at the specified time interval per the falls incident notes was not updated on the resident's written plan of care. RPN #123 further revealed that resident #003's information on the PSW assignment sheet was also not updated.

Interview with ADRC #114 confirmed that resident #003's written plan of care was not updated after his/her fall interventions were revised due to his/her recent falls.

b) Review of resident #004's eating focus in his/her written plan of care revealed that the resident is provided a mechanically altered diet. Review of resident #004's current written plan of care revealed that an intervention was to ensure resident #004's identified assistive eating device was in place. Review of the resident's RAI-MDS records revealed that the resident has not had the identified assistive eating device in place for two years.

During the course of the inspection, observation of resident #004 revealed that resident was not using the identified assistive eating device at mealtimes.

Interview with PSW #116 revealed that the resident has not been using his/her identified

assistive eating device for one or two years and that he/she was not able to locate the identified assistive eating device. Interviews with resident #004 revealed that he/she was not using the identified assistive eating device. Interview with resident #004's Substitute Decision Maker (SDM) revealed that the resident has not been using the identified assistive eating device for a few years.

Interview with RPN #113 revealed that resident #004 has not been using the identified assistive eating device for a period of time. He/she further revealed that resident #004's written plan of care should have been updated when the resident was no longer required the identified assistive eating device at mealtimes.

Interview with ADRC #114 confirmed that resident #004's written plan of care was not updated when the care set out is no longer necessary.

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 to ensure that:
1) there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
2) the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other,
3) the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
4) the provision of the care set out in the plan of care is documented, and
5) the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident-staff communication and response system was accessible by resident #008 in an identified location.

Observation made on an identified date on an identified unit revealed that an identified room door open and left ajar by a wooden wedge at the bottom of the door. The inspector knocked on the door and entered the identified room when there was no response. The inspector noted resident #008 in the identified room. The call bell was noted about two feet behind the resident and dangling on the wall. The resident would not be able to reach the call bell in his/her position. The inspector waited for three minutes and PSW #101 came out from an identified resident's room across the hall into the identified room.

During an interview, PSW #101 stated that he/she had to attend to another resident as requested by another staff and left the resident momentarily. The PSW admitted not ensuring the call bell was within reach by the resident prior to leaving the resident alone. The PSW stated that the resident was able to use the call bell.

Interview with ADRC #102 confirmed that the home's expectation was not to leave resident alone while using the identified transfer device, and staff should ensure that the call bell was within reach for the resident.

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 to ensure that the resident-staff communication and response system is accessible by residents in every area, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of the home's policy titled "Falls prevention and Management Program" (policy #:CIP-I-01, revised June 2016) indicated that the registered staff were to use the Morse Fall Scale to assess each resident's risk for falling upon admission, re-admission, with any significant change in health status and when the resident had frequent falls (such as two or more falls in a month).

a) Review of resident #006's progress notes revealed that the resident had three falls in an identified month. Record review failed to reveal a Morse Fall Scale assessment for resident #006's risk for fall after the resident experienced three falls in the above-mentioned month.

Interview with RPN #104 revealed that Morse Fall Scale was not completed for resident #006 after the three falls occurred.

Interview with ADRC #114 revealed that the Morse Fall Scale was completed when a resident is admitted and re-admitted from hospital, not when the resident experienced frequent falls. Interview with Interim ED revealed that post fall assessment should be completed when a resident experienced two or more falls in a month by using the Morse Fall Scale. Interim ED confirmed that post fall assessments were not conducted for resident #006 after his/her three fall incidents.

b) Review of resident #002's progress notes revealed that the resident had three falls in an identified month. Record review failed to reveal a Morse Fall Scale assessment for

resident #002's risk for fall after the resident experienced three falls in the identified month.

Interview with RPN #104 revealed that Morse Fall Scale was not completed for resident #002 after the three falls.

Interview with ADRC #114 revealed that the Morse Fall Scale was completed when a resident is admitted and re-admitted from hospital, not when the resident experienced frequent falls. Interview with Interim ED revealed that a post fall assessment should be completed when a resident experienced two or more falls in a month by using the Morse Fall Scale. Interim ED confirmed that post fall assessments were not conducted for resident #002 after his/her three fall incidents.

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 to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

Observation made an identified date revealed that PSW #100 was providing an identified care measure to resident #007 in the hallway. There was another resident and one staff in the hallway at the time. The inspector asked the PSW what would be the expectation of the home as to when and where the identified care measure was to be provided to residents. The PSW stated staff would usually provide the identified care measure after giving the resident a shower, and stated it should be done in private including the resident's room and not in the hallway when there were other residents.

Interview with ADOC #102 confirmed that care should be provided in private and the resident's rights to be afforded privacy in caring for his or her personal needs should be respected and promoted.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director is informed of an incident under subsection (3) where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, and the injury has resulted in a significant change in the resident's health condition.

An identified Critical Incident Report (CIR) was submitted to the Ministry of Health and Long Term Care related to a fall incident that revealed resident #006 sustained an injury from the fall.

Review of resident's progress notes revealed that resident #006 had a fall on an identified date, and the resident was sent to the hospital on the same day. Review of the progress notes revealed that the resident received treatment for the identified injury in the hospital the next day.

Review of the above-mentioned CIR revealed that resident #006 had a fall on an identified date, and the CIR related to the incident was submitted to the Ministry of Health and Long Term Care four days later.

Interview with the Interim ED revealed that the next day after the fall incident, the home was aware of the significant change of resident #006's health condition caused by the fall. The interim ED confirmed that the home did not submit the CIR within one business day as required.

Issued on this 8th day of February, 2017

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

Original report signed by the inspector.