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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 2, 2018	2017_484646_0017	013605-17, 013765-17, 014422-17, 016325-17, 026769-17	Complaint

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), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 7, 8, 11, 12, 13, 14, 15, 2017.

The following inspection was completed:

Complaint Inspections:
Log # 013605-17 related to Prevention of Abuse and Neglect;
Log # 013765-17 related to Prevention of Abuse and Neglect; Falls Prevention; Minimizing of Restraining; and Continence Care and Bowel Management;
Log # 026769-17 related to Prevention of Abuse and Neglect; and Nutrition and Hydration, Medication; Dignity, Choice and Privacy; Reporting and Complaints;
Log # 014422-17 related to Responsive Behaviours; and
Log # 016325-17 related to Prevention of Abuse and Neglect; and Personal Support Services.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Resident Care (DRC), Assistant Directors of Resident Care (ADRC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Occupational Therapist (OT), Social Worker (RD), Registered Dietitian (RD), Dietary Aides, Substitute Decision-Makers (SDM) and Residents.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including 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
Hospitalization and Change in Condition
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **4 WN(s)**
- **1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A complaint (#013765-17) was submitted to The Ministry of Health and Long-Term Care (MOHLTC) related to concerns for care provided to resident #002, specifically that the staff had not been assisting the resident at an identified time resulting in the resident missing meals. The management told the complainant that the resident was refusing to get out of bed, and also refusing to eat.

Interview with the complainant revealed that as per resident #002's plan of care, at an identified time of day, the staff were to check on the resident at a specified frequency to see if resident would like to get up and not miss the identified meal.

On an identified date at an identified time, interview with Personal Support Worker (PSW) #124 revealed that resident #002 was still in bed at an identified time when the resident was to be up. Observation conducted with the PSW after the interview revealed that the resident was awake and dressed up in clothing but still lying in bed. Interview with the PSW revealed that the resident was willing to get out of bed, however, PSW #124 stated that the written plan of care guided the staff to get the resident up at a later time, according to the family's preference.

Observation of resident #002 on the same day at a later time, revealed that after the resident was provided morning care, he/she was placed in the activation room, to attend the program. When inspector asked the PSW #124 if the resident had the identified meal,

the PSW stated the snack was about to come and the resident will be given alternative for the identified meal. However the PSW went to the servery immediately and brought food for the resident.

Review of the resident written plan of care revised on an identified date revealed that the resident's family preferred that staff get the resident up at a specified time, as tolerated , and if the resident refused, staff were to try at a specified interval of time, if possible. Further the plan of care failed to reveal that directions were given to the staff on what to do if the resident was up after the identified meal was served.

PSW #124 indicated in an interview that he/she knows only that the resident has to be up at an identified time, not before, and to be ready for the next identified meal. Further, the PSW stated that usually the resident is in bed at the identified time and he/she was not sure what the rest of the plan of care meant, as there was no clear direction if they have to wake up resident at the at the earlier or later time, and if the resident is up, but missed the identified meal, what the staff were to offer to the resident.

Interview with registered dietitian (RD) #111 revealed that there was no specific direction to the staff what to offer resident #002 if he/she missed the identified meal.

Interview with Assistant Director of Resident Care (ADRC) #107 confirmed that resident #002's written plan of care did not set out clear directions to staff and others who provide direct care to the resident as to when staff are to get the resident up from bed and what the staff is to do if the resident misses his/her identified meal. [s. 6. (1) (c)]

2. The licensee has failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

A complaint (#013765-17) was submitted to the MOHLTC regarding family concern for resident #002's care related to falls.

Review of resident #002's written plan of care on an identified date revealed that resident had been identified for high risk for falls related to identified factors.

The goal set was the resident will have no fall incident within the three months period. Intervention to reach the goal were:
- staff to apply special approach during intentional safety check,
- to ensure personal belongings and call bell is within a reach,

- a specified bed with an identified number and type of falls prevention devices,
- another two identified falls prevention device when resident is in bed and in an identified assistive mobility device,
- placing the resident at an identified area for observation,
- monitor risk for falls related to use of identified medications

Further review of resident #002's written plan of care revealed that the resident had identified risks when the resident used their identified assistive mobility device, and when the resident used the identified mobility device, it was to be set up in an identified manner at two identified periods of time in the day.

On an identified day at an identified time, during the inspection period, the inspector was notified that resident #002 was found at an identified resident’s area beside the resident’s identified mobility device.

Interview with Registered Practical Nurse (RPN) #108 revealed that the resident was observed by the housekeeping staff to be sliding down off the identified assistive mobility device, and there was no staff in the room to monitor the resident. At the time when housekeeping staff tried to find staff to assist the resident, the resident had slid down to an identified location. The RPN further confirmed that the falls prevention device when the resident is in their assistive device did not alert the staff, and when the RPN checked the falls prevention device, the falls prevention device was not properly set up. The RPN also confirmed that the resident was not assisted to bed before the identified time as the plan of care directed the staff, because at an identified time that day, a technician came to fix the resident's identified assistive mobility device, and the resident did not wanted to go to bed.

Interview with PSW #126 confirmed that he/she did not assist the resident to go to bed as the plan of care directed him/her and there was no staff in the activation room to monitor the residents as all the staff was away attending the report.

Interview with the ADRC #113 confirmed that the staff are expected to follow the direction in the resident's written plan of care and to notify the registered staff or ADOC of any changes. Further, the ADOC confirmed that the staff were to make sure the residents in the activation room are monitored by a nursing staff, the staff is expected to make sure the identified falls prevention device on the resident’s assistive mobility device is checked and is in working condition, and the staff was to assist resident #002 to bed as directed from the plan of care.

Interview with the DRC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. This inspection had been initiated in response to several complaint (Logs #013605-17, 013765-17, 026769-17) related to alleged resident-to-resident abuse on an identified date, alleging resident #001 had an identified interaction with resident #002, and this was witnessed by a family member of resident #002.

A review of resident #001's clinical records identified the resident to have a number of identified responsive behaviours.

Review of residents #001's progress notes over the month of June revealed:

- On an identified date, resident #001 was in an identified resident's area, and had attempted to direct an identified responsive behaviour towards both resident #002 and resident #002's family member. DOS monitoring was started for resident #001 after the incident.

- On another identified date, resident #001 had exhibited an identified responsive behaviour toward a co-resident who was in the same identified residents' area. One-to-one monitoring was initiated for resident #001, and the resident also continued on DOS monitoring.

- On the third identified date, the family member of resident #002 reported that resident #001 had attempted to exhibit the same identified responsive behaviour toward resident #002 near another identified residents' area. Review of the progress notes for resident #002 revealed that the staff for the 1:1 monitoring was on break at the time, and the RPN was away for an identified break and the regular floor staff was doing documentation.

Review of the progress notes further revealed a Care Concerns note, on an identified date, attended by the managers and interdisciplinary team, where resident #001's identified responsive behaviours, including using his/her assistive mobility device to hit other residents' assistive devices. Follow-up actions from the meeting included: DOS and 1:1 monitoring, and referral to identified health providers.

Review of resident's identified assessment, on an identified date, revealed that the interventions in place for resident #001 at the time included the second identified

monitoring intervention. Interview with ADRC #116 revealed that second identified monitoring intervention for resident #001 began on identified date on for an identified period of time during the day, as the home determined these were the hours when resident #001's identified responsive behaviours occurred.
Review of the identified documentation for 1:1 monitoring for an identified range of dates revealed that the home had implemented the monitoring at the specified time in the day, but on the date of the third incident above, there was no staff available for a period of time within the usual scheduled time for the 1:1 monitoring.
Interview with ADRC #116 and the DRC revealed that the plan for managing resident #001's responsive behaviours at the time included the DOS and 1:1 monitoring intervention, and this started on an identified date prior to the third identified incident.

The ADRC further revealed that on the identified date of the third incident, there was a shortage of staff and the 1:1 staff was not available for resident #001 at the identified period of time within the usual monitoring time, and the incident had occurred within that time when there was no scheduled staff available.

Interview with the DRC revealed that the plan of care had not been provided to resident #001 as specified in the plan at the time of the third incident. [s. 6. (7)]

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 (c) clear directions to staff and others who provide direct care to the resident, and
2) The care set out in the plan of care is provided to the resident as specified in the plan,, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure and fully respect and promote the resident's right to be afforded privacy in treatment and in caring for his or her personal needs.

This inspection had been initiated in response to complaints (Logs #013605-17, 013765-17, 026769-17) related to the provision of dignity and respect towards resident #002 during care.

Interview with the complainant revealed on an identified date, he/she had seen resident #002 seated and the resident was not properly dressed so that an identified part of the resident's body was exposed.

Review of progress notes did not reveal any documentation of the alleged incident. Review of the home's internal investigation report revealed that ADRC #107 received notification the day after the date of the identified incident regarding concerns from the family member of resident #002, that the resident was exposed in the in the identified residents' area.

From the investigation notes, PSW #122 was getting resident #002 ready for an identified care. The PSW #122 revealed that he/she and another PSW had removed the an identified piece of the resident's clothing, and had placed an identified covering for resident #002's identified section of the body, and had sat the resident down on an identified device for the identified care the staff were to perform, and the staff were transferring the resident from his/her room to the identified room for the identified care. Further review of the documentation revealed that PSW #122 had revealed that resident #002 may have moved while sitting on the identified device, and his/her identified part of the body was exposed. PSW #122 had agreed that the resident's privacy was not protected during care.

PSW #122 was not working in the home at the time of the inspection, and was not

available for interview.

Interview with ADRC #107 revealed that his/her investigation of the incident revealed that it was PSW #122 who provided resident #002 care at that time. ADRC #107 revealed that, although resident #002's room was close to the room for the identified care, there was still an identified distance between the two rooms where the resident would be exposed to the public identified residents' area. The ADRC further indicated that the identified device for the identified care did not offer body coverage, and the covering that the staff used would only partially cover the resident, exposing the resident's identified area of the body.

ADRC #107 further revealed that this method of transferring resident is not normal practice of the home, and that it was his/her expectation for staff to provide the identified care for residents when the residents are in the specified room for the care.

Interviews with ADRC #107 and the DRC revealed that the resident's right to privacy during care had not been fully respected and promoted. [s. 3. (1) 8.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee had failed to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

This inspection had been initiated in response to complaints (Logs #013605-17, 013765-17, 026769-17) related to concerns with the home's handling of complaints.

Under the Long-Term Care Homes Act (LTCHA), 2007, c. 8, s. 22 (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

Review of the home's policy, titled "Concerns and Complaints from Long Term Care Residents and Families," (Policy Number CAD-IX-04, Reviewed/Revised Date: November 2017) revealed that, for written complaints, the Ministry of Health will be informed of all written complaints in relation to the mandatory reporting issues covered by the LTCHA by the ED or designate as per requirement.

Interview with the Executive Director (ED) and DRC revealed that the abovementioned home's policy for concerns and complaints of residents and family instructs the ED or designate to inform of the Ministry only when written complaints are in relation to mandatory reporting issues covered by the LTCHA, but review of the LTCHA, c.8, s.22(1) revealed that all complaints concerning care of a resident or operation of the long-term care home should be immediately forwarded to the Director. The ED and DRC confirmed that the home's concerns and complaints policy currently did not comply with the regulations, and needs to be updated regarding the forwarding of complaints to the Director. [s. 21.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints was received concerning the care of a resident or the operation of the long-term care home was immediately forwarded it to the Director.

This inspection had been initiated in response to several complaints (Logs #013605-17, 013765-17, 026769-17) related to: alleged resident-to-resident abuse by resident #001 toward resident #002, improper care of resident related to nursing and nutritional care, dignity and respect of resident during care, and concerns with the home's handling of complaints.
Review of the home's record of written electronic correspondence with the SDM of resident #002, concerning the care of resident #002 on a number of identified dates.

Review of the records revealed that the DRC had responded in writing to the complainant. However, no records of the complaints were forwarded to the Director.

Interview with social worker (SW) #118 revealed that he/she had not received any written complaints from the family of resident #002, but had been involved in in-person meetings with them. He/she further revealed that when he/she received written communication from family, he/she will verify with the family if it is a complaint or a concern. He/she further revealed that the family of resident #002 would likely have indicated a complaint.

Interview with the Executive Director (ED) revealed that the home's process for handling written complaints from family regarding care of residents or operation of the home, would be to ask SW #118 to contact the family first to ask if it is a complaint or concern. If it is a written complaint, which is often in the form of e-mail, the home would send the report to the ministry.

Interview with the DRC revealed he/she has received written communication from the family, and had responded to the family, but had not forwarded the written complaints from the family to the ministry. Further Interviews with the DRC and ED revealed that the written complaints should have been forwarded to the Director. [s. 22. (1)]

Issued on this 7th day of February, 2018

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

Original report signed by the inspector.