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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2019	2018_578672_0012	024164-17	Follow up

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 26, 27, and July 4, 2018

The purpose of this inspection was to follow up on Log #024164-17, related to a Compliance Order issued within Inspection #2017_539120_0048, on October 17, 2017, pursuant to O. Reg 79/10, s. 15 (1), with a compliance due date of March 31, 2018.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Social Worker (SW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident's family members, volunteers, and residents.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2017_539120_0048	672

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	Légende 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).

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 :

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

Related to Log #024164-17:

Inspector #672 completed a follow up inspection related to a Compliance Order issued to the licensee on October 17, 2017, within inspection #2017_539120_0048, related to bed rails and bed systems in the home. During the follow up inspection, Inspector #672 completed a tour of two resident home areas, and observed the use of bed rails on each of the resident home areas. During the tour, Inspector #672 observed that many of the beds had bed rails present. Inspector #672 observed resident #001's bed system, which had bilateral bed rails, both in the engaged position. The sign above resident #001's bed indicated that the bed rails were to be used for a specified purpose.

Resident #001 was admitted to the home on a specified date, with multiple medical diagnoses.

During an interview, PSW #106 indicated that the bed rails were present on resident #001's bed for a purpose other than the purpose indicated in the sign above the resident's bed.

Inspector #672 observed resident #001 while in bed. The resident was not observed to utilize the bed rails for the purpose indicated in the sign above the resident's bed.

During record review, Inspector #672 reviewed resident #001's current written plan of care, which indicated that resident #001 required the bed rails for a purpose other than the purpose indicated in the sign above the resident's bed.

During an interview, resident #001's family member indicated that the bed rails were in place for a purpose other than the purpose indicated in the sign above the resident's bed, for a specified reason.

During an interview, the DOC indicated that all residents had been assessed for their use of bed rails since the compliance order was received regarding the use of bed rails and bed systems in the home. The DOC further indicated that part of that assessment was the creation of the "Bed Safety Plan" signs hung above each resident's bed, which were supposed to match with the resident's written plan of care.

The licensee failed to ensure that the resident #001's plan of care set out clear directions to staff and others who provided direct care to the resident, related to the reason why the resident utilized bed rails. [s. 6. (1) (c)]

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

Related to Log #024164-17:

During the initial tour of the home, Inspector #672 observed that many of the beds had bed rails present. Inspector #672 observed resident #005's bed system, which had bed rails in the engaged position.

Resident #005 was admitted to the home on a specified date, with multiple medical diagnoses.

Inspector #672 reviewed resident #005's plan of care. The current written plan of care

indicated that resident #005 utilized the bed rails for a specified purpose, required a specified level of assistance from an identified number of staff members during transfers and bed mobility, where the staff were expected to implement identified interventions.

Inspector #672 observed resident #005 being transferred into and out of bed on a specified date and time. During the transfer, the resident was assisted by an identified number of staff members, in a different way and with a different number of staff members than was identified in the resident's plan of care. Inspector #672 then observed resident #005 being assisted with repositioning in the bed, without the staff implementing the identified interventions listed within the plan of care.

During an interview, PSW #106 indicated that resident #005 did not utilize the bedrails for the purposes indicated in the plan of care, and required an identified number of staff members to provide assistance, due to specified reasons. PSW #106 further indicated that resident #005 required an identified number of staff members to assist with transfers under specific circumstances, otherwise a different number of staff members could assist the resident.

During an interview, the DOC indicated that all resident plans of care had been reviewed and revised since October 2017, related to bedrails. The DOC further indicated that the expectation in the home was that care was provided to the residents as specified in the plan of care.

The licensee failed to ensure that resident #005 received care as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed, or care set out in the plan was no longer necessary.

On a specified date, Inspector #672 observed resident #006 being transferred into the bed by PSWs #106 and #107, who utilized a specified device . Both staff members then repositioned the resident in the bed. Resident #006 was not observed to utilize the bed rails in any way during the transfer or repositioning/bed mobility.

Resident #006 was admitted to the home on a specified date, with specified medical diagnoses.

Inspector #672 reviewed resident #006's plan of care. The current written plan of care indicated that resident #006 required an identified number of staff members to provide a specified level of assistance to transfer in/out of bed, and required an identified number of staff members to assist with bed mobility, due to a specified condition.

During an interview, PSW #107 indicated that resident #006 required a different number of staff members to assist with all transfers, utilizing a specified device. PSW #107 further indicated that resident #006 did not utilize the bed rails at all during transfers or bed mobility, due to specified reasons and conditions.

During an interview, RPN #104 indicated that resident #006 required a specified level of care and device for all transfers, due to specified reasons and conditions, which had been present for an identified period of time.

Inspector #672 reviewed resident #006's health care records, and did not observe documentation to indicate that the resident's health status, level of care, level of assistance or number of staff members required to assist with activities of daily living had changed over an identified time period.

During an interview, the ADOC indicated that the expectation in the home was that the resident's plan of care was to be updated if a resident's health status changed, and/or the resident required a different level of care, with different interventions than was listed within the plan of care.

The licensee failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 written plan of care for each resident provides clear direction to staff and others who provide direct care to the resident, and ensure that the care set out in the plan 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD was reasonable, in light of the resident's physical and mental condition.

Related to Log #024164-17:

During the initial tour of the home, Inspector #672 observed the use of bed rails on each

of the resident home areas. Inspector #672 then observed resident #006's bed system, which had bedrails present.

Inspector #672 reviewed resident #006's plan of care. The current written plan of care indicated that resident #006 had the bedrails in place for a specified purpose, to assist with identified activities of daily living.

On a specified date, Inspector #672 observed resident #006 being transferred into the bed by PSWs #106 and #107, who utilized a specified device. Resident #006 was not observed to utilize the bed rails in any way during the transfer or repositioning/bed mobility.

During separate interviews, PSW #107 and RPN #104 indicated that resident #006 required a specified device be utilized by an identified number of staff members to assist with all transfers. PSW #107 and RPN #104 further indicated the resident had the bed rails in place for specified purposes, which were different than the reasons listed in the resident's plan of care due to specified reasons and conditions, which had been present for an identified period of time. RPN #104 indicated that identified bedrails had been present on the bed when resident #006 moved in, and the resident had never been assessed for the usage of the identified bedrails.

During an interview, the DOC indicated that all recommendations and orders for residents to utilize PASDs were captured within an assessment, which was completed within Point Click Care (PCC).

Inspector #672 then reviewed the assessments section in PCC, and observed that resident #006 had an assessment completed on a specified date, which indicated that resident #006 required identified bedrails for specified purposes. There was no mention within the assessment that resident #006 required other identified bedrails present for any purposes.

Inspector #672 then observed a quarterly review of the assessment which was completed on a specified date, which indicated no changes to the recommendations from the previous assessment were required. There were no other assessments noted to have been completed for resident #006.

The licensee failed to ensure that the use of a PASD under subsection (3) to assist resident #006 with a routine activity of daily living was included in the resident's plan of

care only if the use of the PASD was reasonable, in light of the resident's physical and mental condition. [s. 33. (4) 2.]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD was reasonable, in light of the resident's physical and mental condition.

Inspector #672 observed resident #009's bed system, which had identified bedrails present, with identified interventions in place.

On a specified date, Inspector #672 observed resident #009 being transferred into the bed by PSW #103 and the ADOC. Both staff members then assisted the resident with repositioning in the bed. Resident #009 was not observed to utilize the bed rails in any way during the transfer or repositioning/bed mobility.

Resident #009 was admitted to the home on a specified date, with identified medical diagnoses.

Inspector #672 reviewed resident #009's plan of care. The current written plan of care indicated that resident #009 had the bedrails in place for identified purposes, to assist with specified activities of daily living. The written plan of care further indicated that resident #009 required an identified number of staff members to provide a specified level of assistance with bed mobility, and the resident required an identified intervention, for specified purposes.

During separate interviews, PSW #103 and RPN #105 indicated that resident #009 required the identified intervention to be in place at all times when the resident was in bed, for specified purposes. PSW #103 further indicated that resident #009 required an identified number of staff members to provide a specified level of assistance, and the resident did not utilize the bed rails in any way.

During an interview, the DOC indicated that all recommendations and orders for residents to utilize PASDs were captured within an assessment, which was completed within Point Click Care (PCC).

Inspector #672 then reviewed the assessments section in PCC, and observed that resident #009 had an assessment completed on a specified date, which indicated that

resident #009 required the bedrails to be utilized as a PASD, for specified purposes.

Inspector #672 then observed a quarterly review of the assessment, completed on a specified date, which indicated no changes to the recommendations from the previous assessment were required. There were no other assessments noted to have been completed for resident #009.

The licensee failed to ensure that the use of a PASD under subsection (3) to assist resident #009 with a routine activity of daily living was included in the resident's plan of care only if the use of the PASD was reasonable, in light of the resident's physical and mental condition. [s. 33. (4) 2.]

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 PASDs are included in a resident's plan of care only if the use of the PASD is reasonable, in light of the resident's physical and mental condition, to be implemented voluntarily.

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.