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

Original Public Report

Report Issue Date: June 19, 2024
Inspection Number: 2024-1361-0003
Inspection Type: Complaint Critical Incident
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Markham, Markham

Lead Inspector	**Inspector Digital Signature**
Natalie Jubian (000744)	Natalie Jubian Digitally signed by Natalie Jubian Date: 2024.07.03 09:19:09 -04'00'

Additional Inspector(s)
Jane Duggan (000838) was present during the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-6, 2024

The following intake(s) were inspected:

- Intake related to a medication incident
- Intake related to a complainant regarding multiple resident care items

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

Medication Management
Infection Prevention and Control
Reporting and Complaints

Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: SPECIFIC DUTIES RE CLEANLINESS OF REPAIR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

Accommodation services

s. 19 (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee failed to ensure the home's furnishings are kept clean and sanitary.

Rationale and Summary

Inspector #000744 noted a chair on a resident home area covered in dried food particles in the hallway adjacent to the end lounge area. The chair was easily accessible to residents. The next day, the chair was noted to be in the same condition, uncleaned.

The Infection Prevention and Control (IPAC) Manager confirmed the chair was in an unclean state and had requested housekeeping to remove the chair off the home area to get deep cleaned, however, the chair was found in the same condition a day later.

Failing to ensure the homes furnishing were kept clean of dried food increased the risk of pests in the home.

Sources: Observations, and interview with IPAC Manager. [000744]

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE- LICENSEE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to immediately forward a written complaint regarding the care of resident #002.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a written complaint made by resident #002's Substitute Decision Maker (SDM). The written complaint was sent to the home's Executive Director (ED) and Assistant Director of Resident Care (ADRC) #106 through electronic-mail (e-mail).

The complaint was related to resident #002's care involving a medication incident. The SDM alleged it was a repeated concern. The complaint was not forwarded to the Director until several days later.

ADRC #106 acknowledged the complaint was received through writing and was regarding resident #002's care.

Failing to immediately forward the complaint to the Director posed no risk to the resident.

Sources: CIR, interview with ADRC #106. [000744]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director was informed immediately of the suspicion and the information of the improper care of resident #002 that resulted in a risk of harm.

Rationale and Summary

A CIR was submitted to the Director related to a written complaint made by resident #002's SDM. The complaint was related to resident #002's care involving a medication incident.

The Ministry of Long-Term Care (MLTC) requested the home to submit a separate CIR related to section 28 of the Fixing Long-Term Care Homes Act (FLTCA), 2021, which outlines the home's responsibility to immediately report any suspicion of improper or incompetent care of a resident that resulted in harm or a risk of harm to the resident. The home submitted an inquiry to the Critical Incident and Triage Team (CIATT) regarding the request for a separate CIR submission. The home was notified again to submit a separate CIR related to section 28 of the FLTCA, 2021, however the home did not feel a separate CIR was required because they felt there was no risk of harm to resident #002 from the medication incident.

Resident #002's clinical records indicated the medication had been signed off as administered, however the medication was found a day later still in the medication cart. Registered Practical Nurse (RPN) #104 stated resident #002 was on the medication for a certain diagnosis. RPN #104 and the Pharmacist acknowledged there was a risk of increased symptoms of the diagnosis due to the missed medication dose.

ADRC #106 acknowledged signing off on a medication that had not been administered could be considered improper or incompetent care of the resident by the registered staff.

Failure to report improper care of resident #002 to the Director placed them at low risk.

Sources: Resident #002's clinical records, home's investigation notes, and interviews with staff. [000744]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to resident #002 in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A CIR was submitted to the Director regarding a complaint from resident #002's SDM. The complaint alleged the resident did not receive their medication dose as prescribed.

Resident #002's clinical records indicated the medication had been signed off as administered, however a progress note the next day, indicated the medication had not been administered, as it was found in the medication cart.

The home's internal investigation notes and ADRC #106 confirmed the medication had not been administered. RPN #104 and the Pharmacist indicated there was a potential risk to the resident experiencing symptoms as a result of the missing the medication dose.

Failure to administer the medication as prescribed to resident #002 negatively impacted their health and well-being.

Sources: Resident #002's clinical records, interviews with staff. [000744]

COMPLIANCE ORDER CO #001 CMOH and MOH

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) The IPAC manager is to develop and implement a process to ensure that all Alcohol Based Hand Rub (AHBR) in the home is not expired.

2) The IPAC manager or management designate shall conduct audits three times a week for five weeks to ensure ABHR is within its expiry date and available in all point of care and common and resident areas. The IPAC manager should analyze the results of the audit and provide corrective measures.

a) The audit shall include the name of the person completing the audit, location of the audit, the date it was completed, and any corrective actions made. The home will keep a documented record of all audits that are completed.

b) Make the records available to the inspector immediately upon request.

Grounds

The Licensee has failed to ensure that staff followed the Infection Prevention and Control (IPAC) Measures requirement as part of the directive issued by the Chief Medical Officer of Health (CMOH).

In accordance to the "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings from the Chief Medical Officer of Health, specified that alcohol based hand rub (ABHR) must not be expired.

Rationale and Summary

During an IPAC tour on a resident home area, an alcohol-based hand rub (ABHR) bottle was found on a railing beside a resident room. The ABHR had an expiry date of January 2024. The conference room on the main floor had two bottles of ABHR with expiry dates of January 2024 and February 2023.

Personal Support Worker (PSW) #100 indicated ABHR found on railings in front of resident rooms were used to perform hand hygiene prior to entering a resident's

room. PSW #100 was seen performing hand hygiene with the expired ABHR while speaking to the inspector. The IPAC Manager confirmed ABHR in all areas of the home should be within its expiry date and the ABHR bottles in the conference rooms had expired.

Failing to provide non-expired ABHR increased the risk for the transmission of infectious agents.

Sources: Observations and interviews with staff. [000744]

This order must be complied with by August 2, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.