Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 5, 2021	2021_814648_0006	000200-21, 012876-21	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 McNicoll
2311 McNicoll Avenue Scarborough ON M1V 5L3

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

JOVAIRIA AWAN (648)

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): September 23, 24, 27, 28, and 29, 2021

The following intakes were completed in this Critical Incident System (CIS) Inspection:
Log #012876-21 related to an allegation of staff to resident abuse,
Log #00200-21 related to a fracture of unknown cause.

During the course of the inspection, the inspector(s) spoke with Housekeeping Staff (HK), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Food Service Manager (FSM), Registered Dietitian, Assistant Director of Care (ADOC), and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed infection prevention and control (IPAC) practices, provision of care, staff to resident interactions, reviewed clinical health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Skin and Wound Care

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)**

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003 was monitored during meals when eating in a location other than the dining area.

Resident #003's plan of care identified they required modified dietary interventions to manage their nutrition related risks.

An observation identified that resident #003 was served their meal in a location other than the dining room. Staff were not observed in the vicinity of the resident during the observation as all floor staff were noted in the dining room which had been observed by the inspector moments earlier for a period of time.

Interviews with the RD, RN #110 confirmed residents not eating in the dining room required supervision for the entirety of their meal, and that resident #003 would require supervision to ensure safe meal times according to their plan of care.

The resident was at nutrition related risk in the absence of staff supervision during the meal.

Sources, inspector #648’s observations; Interviews with the homes PSW and nursing staff, RD, and DOC. [s. 73. (1) 4.]

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 residents eating their meals in locations other than dining areas are monitored during their meals, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

The following observations were conducted by Inspector #648 of the facility during the course of this inspection:

- PSW #111 observed exiting dining room servery towards a resident seated in foyer of nursing station without appropriate application of face mask.
- PSW #102 portered multiple wheelchair bound residents into lounge area from in front of nursing area, and proceeded to enter and exit multiple resident rooms without performing hand hygiene.
- PSW #104 observed removing clothing protectors and meal trays from multiple residents in dining room during lunch meal, proceeded to porter three residents using a walker, and wheelchairs respectively, out of dining room without performing hand hygiene in between touching residents. Hang hygiene was not offered to the identified residents.
- PSW #113 observed applying clothing protectors to residents in the dining room, portering residents into dining room, moving beverages to drink cart, and serving residents in the dining room. PSW#113 entered servery, prepared a thickened beverage and served to a resident in dining room without performing hand hygiene during the observation period.

Observations demonstrated inconsistent IPAC practices performed by the staff of the home, putting residents at risk of harm for possible transmission of infectious agents.

Sources: Inspector #648’s observations; Interviews with the IPAC lead, DOC, PSW and Nursing staff. [s. 229. (4)]

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 all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

Issued on this 7th day of October, 2021

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

Original report signed by the inspector.