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

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Original Public Report

Report Issue Date: November 30, 2022	
Inspection Number: 2022-1291-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Yee Hong Centre for Geriatric Care	
Long Term Care Home and City: Yee Hong Centre - Scarborough McNicoll, Scarborough	
Lead Inspector Diane Brown (110)	**Inspector Digital Signature**
Additional Inspector(s) Eric Tang (529) Reethamol Sebastian (741747)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 4-7,11-14, 17-18, 2022.

The following intake(s) were inspected:

- Intake: #00001719- related to residents sleeping preference, wake-up times and meal service.
- Intake: #00002907- related to a fall with a significant change in health status.

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

Falls Prevention and Management
Pain Management
Infection Prevention and Control
Infection Prevention and Control
Resident Care and Support Services

Food, Nutrition and Hydration
Infection Prevention and Control
Resident Care and Support Services
Food, Nutrition and Hydration
Resident Care and Support Services
Food, Nutrition and Hydration

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement the Infection Prevention and Control standard issued by the Director.

In accordance with O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes as of April 2022, provided additional requirements for IPAC programs in long-term care homes.

During the initial IPAC tour three bottles of alcohol-based hand rub were observed to have expired: two bottles, on third floor had an expiry date of September 2022, and one bottle, on second floor with an expiry date of June 2022.

Two of the three bottles, with the expiry date of September 2022, were replaced on October 6, 2022. The remaining bottle was not. RPN #133 was notified of the situation and confirmed the product was expired. The staff immediately replaced the product.

The IPAC Manger stated that the expired alcohol-based hand rub should not be used on the floor.

Sources: Observations and Interview with RPN #133 and IPAC manager. [741747]

Date Remedy Implemented: October 6, 2022

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a Minister's operational or policy directive was followed related to COVID-19 testing in the home.

Section 9 of the Minister's Directive dated August 30, 2022, stated licensees were required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance for Long Term Care Homes in Ontario, or as amended, were followed.

Infection Prevention and Control (IPAC) lead #117 indicated personal support workers (PSWs) were expected to assess and document residents' daily COVID-19 signs and symptoms on the screening form. The screening form contained two columns: temperature and signs and symptoms of COVID-19.

The signs and symptoms on the COVID-19 screening form were not documented for the third, fourth and fifth floor from October 2 to October 6, 2022.

By not adhering to the home's IPAC program, there could be a possible risk of transmitting the COVID-19 virus to residents, visitors and staff.

Sources: Record review (progress notes and COVID-19 screening forms for residents) and interview with PSW #125, #126 and #127, RPN #121, RN #120 and IPAC lead #117. [741747]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that resident #010's infectious symptoms were recorded every shift.

Resident #010 was suspected to have an infection on September 12, 2022, and a test was ordered. The resident was

subsequently diagnosed with urinary tract infection on September 16, 2022, which resolved on September 23, 2022. There was no documentation regarding the resident's symptoms of infection the night shift of September 11, 2022 and both the days and evenings shift of September 14, 2022.

RN#134 acknowledge the above missing documentation. The IPAC Manager expected staff to document in the progress notes the signs and symptoms of infection on every shift.

Failure to record resident #010's infectious symptoms every shift may compromise the monitoring resident #010's health status.

Sources: Resident #010's health records, and interview with IPAC Manager #106, RN #134. [741747]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received that residents were being woken up earlier in the morning than their preferred, established time.

1. On October 5, 2022, resident #012 was observed at 0550 hours (hrs.) up, dressed and asleep in a chair in the lounge. The resident remained asleep in their chair at 0557 hrs. prior to the Inspectors leaving the unit. An interview with the registered practical nurse stated that resident #012 had been in the lounge since 0530 hrs. The resident's plan of care identified their preferred wake up time was 0630 hrs. which had been in place since 2019.

The resident's cognition was very severely impaired. An interview with the resident's substitute decision maker (SDM) revealed the resident's normal waking time was 0700 hrs. closer to breakfast and that 0530 hrs. was too early to be up and placed in a chair.

The home's policy stated that additions or revisions to the resident's care plan are in collaboration with the residents/SDM and other interprofessional team members.

The resident's plan of care was modified on October 5, 2022, after the Inspectors morning observations, to reflect a wake up time of 0600 hrs. replacing the time of 0630 hrs. There was no supporting documentation of this change. The interview with the SDM revealed they were not involved in the decision to change the resident's wake up time to 0600 hrs.

The follow-up interview with the Director of Care (DOC) revealed that staff changed the resident's care plan based on practice and not based on the home's expectation of resident's need and preference.

2. On October 5, 2022, resident #011 was observed at 0544 hrs. up, dressed and asleep in a chair in their room. At 0711 hrs. the resident remained asleep in their chair. The resident's plan of care identified their preferred wake up time was 0800 hrs.

A review of the PSW assignment sheets identified resident #011 on the 'early bird' list which directed night staff, a 2300 - 0700 hrs. shift, to wake the resident up. A registered staff interview shared that they discuss as a team wake up times; determine who are the candidates for the early bird time and create the PSW assignments.

An interview with the resident's SDM shared that 0544 hrs. was too early for their mother to be dressed and up in a chair stating the resident would just fall asleep in the chair.

The SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care related to their sleep pattern and preference.

3. On October 5, 2022, resident #006 was observed at 0547 hrs. in the Activity Room dressed and watching a Chinese entertainment program. The resident's plan of care identified their preferred time to get up was 0730 hrs.

An interview with the resident revealed their preferred wakeup time was 0700 hrs. and felt 0600 hrs. was too early as when woken up earlier they feel tired.

A review of the PSW assignment sheets identified resident #011 on the 'early bird' list which directed night staff to get the resident up.

On October 6, 2022, following the Inspector's early morning observations, the resident's plan of care was changed to a preferred wake-up time of 0600 hrs. to 0700 hrs. The resident interview and lack of documentation revealed the resident had not been involved in the decision to change the care plan to an earlier wake up time.

The follow-up interview with the Director of Care (DOC) revealed that staff changed the resident's care plan based on practice and not based on the home's expectation of resident's need and preference.

Residents or SDM's were not given an opportunity to participate fully in the development and implementation of the resident's plan of care as it related to wake up times possibly impacting the resident's quality of sleep and day.

Sources: Observations, Record review of care plan, progress notes, PSW assignments, policy #CNU-III-01 entitled Assessment and Care Plans. Revised date February 2022. Interviews with resident #006 and SDM of residents #011 and #012, RPN #121. #124, DOC. [110]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure wake up times identified in the sleeping preferences plan of care were provided to resident #004, #018, and #021.

On October 5, 2022, at 0536 hrs., Inspector #529 observed resident #004 to be sitting in their wheelchair in their room the resident and dressed in daytime clothing. On the same day Inspector #110 and #741747 observed resident #018 to be dressed and in the television room at 0516 hrs. and resident #021 at 0531 hrs.

As of October 4, 2022, the following residents plan of care identified their sleep preference and wake -up times as follows:
Resident #004 at 0730 hrs.;
Resident #018 after 0700 hrs.;
Resident #021 at 0700 hrs.

Interviews with PSWs shared the home's expectation was to follow the resident's plan of care and acknowledged the plans had not been followed.

There was a moderate impact and severity to resident #004, #018, and #021 as their quality of life may have been impacted having been woken up at times earlier than identified with their care plan.

Sources: Electronic clinical records for resident #004, #018, and #021; resident observations; staff interviews with PSW #109, #122 #123. [110]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 29 (3) 21.

The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the resident's sleep pattern and preferences.

On October 5, 2022, resident #024 was observed at 0539 hrs. dressed and asleep in a chair in the activity room. The resident remained asleep at 0705 hrs. On the same day, resident #008 was observed at 0547 hrs. dressed and sitting in the lounge watching a Chinese TV program. In both instances, there were no plans of care in place based on an assessment of the resident's sleep pattern and preferences to ensure their preference of an early morning rising.

On October 5, 2022, resident #025 was observed at 0519 hrs. asleep in bed with the overhead lights on in their bedroom area. The lights remained on at 0630 hrs. while the resident remained asleep. The resident did not have a plan of care in place based on an assessment of the resident's sleep pattern and preferences to ensure their preference of lights on while sleeping.

Staff interview acknowledged the resident care plans failed to include resident's sleep pattern and preferences as required.

There was moderate impact and severity to resident #008, #024 and #025 as their quality of sleep may have been impacted if the home's practice was not consistent with the resident's preference and needs.

Sources: Observations, care plan review, interviews with RPN #119, #118, RN #120 and the DOC. [110]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 45

Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

1. On October 5, 2022, in the early morning (between 0512 hrs. and 0519 hrs.) residents were observed asleep in bed with the overhead lights turned on in their room. No such direction was identified in their plans of care. These observations included:
Resident #016 at 0512 hrs., resident #013 at 0514 hrs. and resident #025 at 0519 hrs.

Resident #016 and #013's preferred waking time, in their plan of care, was 0630 hrs. and 1000-1030 hrs. respectively. Resident #025 did not have a sleep pattern and preference plan of care in place.

An interview with the RPN shared that the practice was to turn the lights on in the resident's room prior to getting them up. A follow-up interview with the DOC revealed this was not the expected practice in the home but rather to allow the residents to wake-up on their own.

2. On October 5, 2022, resident #015 was observed at 0550 hrs. asleep leaning to the left side, with their head in an unsupported, left lateral flexion position while sitting in a wheelchair in the activity lounge. The RPN identified that they turn the turn the lights on at 0530 hrs. prior to getting the resident up. A record review identified documentation on the prior shift that resident #015 was dull, tired looking, less speech, lower limb weakness and unable to stand and refused to eat. Resident #015's plan of care identified their wake- up time as 0630 hrs. The resident's condition continued to deteriorate. Later that day the resident was transferred to hospital and passed away a few hours after admission.

The DOC shared that the home supports resident's individualized comfort, rest and sleep by respecting the resident's wake-up preference in the plan of care. Resident #015's comfort, rest and sleep were not supported with earlier morning wake-up along with their change in condition.

3. On October 5,2022 at 0545 hrs. resident #022 was observed being transferred from the bed into a chair. At 0707 hrs. the resident was asleep in their chair in the TV room. The resident's care plan identified 1000 hrs. as their preferred wake-up time. On October 13, 2022, the resident's care plan was changed to reflect a wake-up time of 0600 hrs. There was no record to reflect a rational for the change. The DOC shared that registered staff were updating the resident's sleep preference care plans after the Inspector's morning observation to reflect the practice in the home, but the expectation was to ensure that changes reflect resident's needs and preferences.

There was moderate impact and severity to residents as their comfort, rest and sleep may have been impacted by overhead lights on while sleeping and early morning wakeups.

Sources: Electronic clinical records for resident; resident observations; staff interviews with RPN #124 and the DOC. [110]

WRITTEN NOTIFICATION: Menu Planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that the planned menu items were offered and available at breakfast.

A complaint was received by the Ministry of Long-Term Care reporting that breakfast foods were being placed on the dining room tables by PSWs at least an hour prior to residents entering the dining room.

A digital record was provided to Inspectors supporting the early placement of breakfast foods on the tables.

PSW #123 and dietary aide (DA) #130 confirmed PSWs were placing breakfast on dining room tables one to two times a week in one home area. The Food Service Manger (FSM) acknowledged that PSW's are to offer and serve the meals to residents after they arrived in the dining room.

Residents were not offered an opportunity to choose their meals which may impact their enjoyment of the meal and overall food intake.

Sources: Digital record**,** policy CDS-IV-03 Dining Room- Service Procedures Reviewed date August 2021, Job Description dietary Aide 09/01/2020, Food Service Worker 09/01/2020 and Personal Support Worker 09/01/2020 and interview with DA # 130, PSW #123 and FSM #131. [741747]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that resident #001 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when exhibiting altered skin integrity.

Resident #001 experienced an unwitnessed fall on July 17, 2022 resulting in a skin injury near the resident's left eyebrow. The home's policy indicated that a skin or wound assessment was to be completed by a RN or RPN upon discovery of an altered skin integrity.

Both RPN #116 and the Director of Care confirmed that a skin assessment tool was not completed for resident #001 after their fall with skin injury as required.

There was a moderate impact and severity to resident #001. By failing to complete the skin assessment tool a comprehensive assessment of the skin injury may not have occurred.

Sources: Resident #001's clinical records; home's policy on Skin Care and Wound Management Program reviewed/revied in August, 2021; staff interview with RPN #116 and the Director of Care. [529]

WRITTEN NOTIFICATION: Pain Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that resident #001 was assessed using a clinically appropriate assessment instrument specifically designed for this purpose when resident's pain was not relieved by initial intervention.

Resident #001 had experienced an unwitnessed fall on July 17, 2022, resulting in a skin injury near the left eyebrow with pain. An ice pad was immediately applied to the area, but the resident continued to experience pain later in the evening. The home's policy required that a pain assessment tool be completed by the RN or RPN.

RPN #116 confirmed resident #001 had experienced a new pain to the injured eye area after the fall and that an ice pad was applied with the purpose of reducing the injury and pain. RPN #116 acknowledged that the resident continued to experience unrelieved pain when re-assessed the same evening. Both RPN #116 and the Director of Care indicated that a

pain assessment tool was not completed as required when the initial pain intervention was ineffective in relieving the pain, and that a pain assessment tool should have been completed at that time.

There was a moderate impact and severity to resident #001 as the presence of unrelieved pain may have affected their quality of life.

Sources: Resident #001's clinical records; home's policy on Pain Management Program with reviewed/revised date of August, 2021; staff interview with RPN #116 and the Director of Care. [529]

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