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: December 9, 2024
Inspection Number: 2024-1291-0003
Inspection Type: Critical Incident
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Scarborough McNicoll, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4 to 6, 9, 2024

The following intake(s) were inspected:

- an intake related to falls prevention and management.
- an intake related to Infection Prevention and Control (IPAC)

The following intakes were reviewed:

- three intakes related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a Personal Support Worker (PSW) used safe transferring techniques when they transferred a resident without a second staff member present. The home's investigation notes and the resident's plan of care indicated they required two staff for transfers.

Sources: A resident's clinical records, the home's investigation notes, interviews with staff.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident self-reported a fall, a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls was completed. A resident self reported a fall to their family

member who then informed the registered staff. The resident's clinical record indicated that there was no documented post fall assessment until days later.

Sources: A resident's clinical record, the home's Falls Prevention and Management Program policy and interviews with staff.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument. Investigation notes and a resident's clinical record indicated that the resident had scheduled analgesic and complained of pain. There was no documented pain assessment when they complained of pain and interventions to manage the resident's pain were delayed.

Sources: A resident's clinical record, Investigation notes, Risk Management, Interviews with staff.