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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2017	2017_324535_0017	023942-17	Resident Quality Inspection

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 FINCH
60 Scottfield Drive SCARBOROUGH ON M1S 5T7

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

VERON ASH (535), JANET GROUX (606), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 24, 25, 26, 27, 30, 31, and November 1, 2017.

The following critical incident was inspected during this inspection: log # 26599-15 (related to CIS #2934-000017-15 - transfer and lift).

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director (ED), Acting Director of Resident Care (DRC), Associate Director of Resident Care (A-DRC), Registered Nurses (RN), Registered Practical nurse (RPN), Personal Support Workers (PSW), Resident Assessment Instrument-Minimum Data Set (RAI-MDS-C) Coordinator, Registered Dietitian, President of Family Council, President of Resident Council, Residents, and Substitute Decision Maker (SDM).

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident right was fully respected and promoted to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

During an interview in stage one of the Resident Quality Inspection; resident #001 stated that he/she felt a lack of dignity and respect related to an incident which occurred in the home on an identified date.

Record review revealed that resident #001 was assessed using the home's Minimum Data Set to have consistent and reasonable decision-making. Record review and multiple staff interview revealed that resident #001 displayed responsive behaviors towards staff and other residents in the home.

Record review revealed that the resident was referred and followed by the interdisciplinary team in the home which met monthly. Record review revealed that the team provided emotional support and offered suggestions and interventions to help the resident's responsive behaviors. During an interview, the interdisciplinary team nurse #115 stated that the resident was discharged from the program after he/she improved. However, although there was intermittent display of responsive behaviors from the resident and especially during the time of the incident which occurred on the identified date, the resident was not referred back to the team for continued support.

Record review and staff interviews revealed that on the identified date, it was alleged that resident #001 had an altercation with another resident in the home. Record review of the internal investigative notes and an interview with the Acting ED, revealed that resident #001 denied the incident occurred. According to the Acting ED, during the investigative interview, resident #001 stated that on the night of the alleged incident, he/she was in the specific lounge.

Multiple staff interviews with PSW #116, RPN #114, RN #115, confirmed that resident #001 had not displayed responsive behavior which caused harm to anyone since residing in the home. Record review revealed that after the incident occurred, resident #001 was placed on one to one monitoring and observation for a number of days. As documented on the monitoring and observation records, resident #001 left his/her room and slept in the specific lounge frequently during the observation period.

During an interview, registered staff #114 stated that sometimes resident #001 still informed the staff that nobody trusted him/her because they did not believe he/she did

not cause the altercation with the other resident. The staff stated that resident #001 still felt really unsettled about the incident. During an interview, social worker #129 stated that he/she provided support to the resident during the incident; and that the resident was affected by the incident.

During interviews, the social worker, Acting DRC and Acting ED acknowledged that they understood the reason why resident #001 would feel a lack of dignity and respect; however they were obliged to follow the home's investigative process as a result of this incident. During the interview, the Acting ED stated that the resident was experiencing episodes of tiredness and a lack of sleep which caused the responsive behaviors to return; in addition, he/she stated that they did not think of re-engaging the interdisciplinary support team during the incident. [s. 3. (1) 1.]

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 the resident right is fully respected and promoted to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 care set out in the plan of care was provided to the resident as specified in the plan.

Review of an identified Critical Incident (CI) revealed report of an injury to resident #006 when positioning during his/her bath which required the resident to be transferred to the hospital for further assessment.

Review of progress notes indicated that PSW #102 reported to RPN #103 that he/she had found an injury on resident #006 after his/her bath. The RPN assessed resident #006 and noted the resident had an injury; and notified the physician and the resident's SDM and the decision was made to transfer resident #006 to the hospital for assessment. The resident was transferred to the hospital and returned to the home on the same date.

Review of resident #006's written plan of care directed staff to provide total assistance for bathing by two staff, and use the mechanical lift for transfer.

Interview with PSW #102 indicated he/she received assistance from PSW #118 to transfer resident #006 from his/her bed to the spa room. PSW #102 indicated that once he/she and PSW #118 positioned resident #006 in the tub, PSW #118 left the spa room to assist another resident with care. PSW #102 indicated he/she gave resident #006 a bath by him/herself.

Interview with PSW #118 indicated he/she assisted PSW #102 to transfer resident #006 from the resident's bed and brought the resident to the spa room. PSW #118 indicated he/she did not assist PSW #102 to bathe resident #006.

Interview with the Acting DRC indicated that resident #006's plan of care directed staff to have two staff when bathing the resident and this was not followed by the staff. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

During an interview in stage one of the Resident Quality Inspection; resident #001 stated a lack of dignity and respect was felt during an incident which occurred in the home on March 18, 2017.

Record review revealed and staff interview confirmed that on an identified date, it was alleged that resident #001 had an altercation with another resident in the home. The resident's electronic and paper documentation revealed that during the investigative period, resident #001 was placed on one to one monitoring and observation for a number of days; however a review of the resident written care plan revealed the one on one PSW monitoring and observation was still listed as a current intervention. During an interview, registered staff #114 confirmed that the resident's care plan was not revised and updated because the one to one monitoring and observation should not be included in the current plan of care.

During an interview, the Acting DRC stated that the expectation was that registered staff review, revise and update residents care plan to reflect current care and interventions to be provided. [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 care set out in the plan of care was provided to the resident as specified in the plan; and
- to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of an identified Critical Incident (CI) reported an injury to resident #006 when positioning during his/her bath requiring the resident to be transferred to the hospital for further assessment.

Review of an identified progress note indicated that PSW #102 reported to RPN #103 that he/she had found resident #006's with an injury after his/her bath. The RPN assessed resident #006 and noted the resident had an injury; and notified the physician and the resident's SDM and the decision was made to transfer the resident to the hospital. The resident was transferred to the hospital and returned to the home on the same date.

Interview with PSW #102 indicated he/she receive assistance from PSW #118 to transfer resident #006 from his/her bed to the spa room. PSW #012 indicated that once he/she and PSW #118 positioned resident #006 in the tub, PSW #118 left the spa room to assist another resident with care. PSW #102 indicated he/she gave resident #006 a bath by him/herself. Interview with RPN #103 indicated that PSW #102 reported to him/her that resident #006's sustained an injury during the bath. The RPN indicated he/she assessed the resident's after the resident was returned to his/her bedroom.

Interview with the Acting DRC indicated that the home had completed an investigation and discovered that the resident sustained an injury in the spa room during the bath. The home has failed to use safe transferring and positioning devices or techniques when assisting resident #006 during care. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Resident #003 was triggered for incontinence from most recent filed minimum data set (MDS) during stage two of the resident quality inspection (RQI).

Review of resident #003's resident assessment-minimum data set (RAI-MDS) assessment record on the home's electronic documentation system revealed that a MDS assessment was completed on an identified date and resident #003 was documented as being continent of bladder with the use of a continent device. Further review of the RAI-MDS record revealed that a MDS assessment was completed on another identified date, and that resident #003's continence level had declined from continent of bladder to frequently incontinent.

Review of resident #003's continence assessment record revealed that a continence assessment was completed on an identified date and resident #003 was identified as being continent of bowel and bladder; however after the continent device was removed, a continent assessment was not completed using the home's clinically appropriate assessment tool to reflect the resident's declined change in status.

In interviews, RPNs #114 and #122 stated that resident #003's continence level had declined, and confirmed that they had not complete a continent assessment since

resident #003 was not assigned to them.

In an interview, RPN #123 confirmed that resident #003's continence level had declined, but stated he/she was not aware that a continence assessment was to be completed when the resident's continence level changed, as he/she was newly hired.

In an interview, ADRC #125 stated resident #003's continent device was discontinued and then he/she became incontinent of bladder. ADRC #125 further stated that registered staff should have assessed resident #003 when his/her continence level declined. [s. 51. (2) (a)]

2. During the Resident Quality Inspection (RQI) resident #005 triggered for Incontinence by the home Minimum Data Set – most recent assessment.

Record review revealed that on an identified date the resident was coded as being frequently incontinent for bowel and tended to be incontinent for bladder; and in February 2017, the resident was coded as usually continent for bowel and incontinent episodes once per week or less for bladder. During an interview, Resident Assessment Instrument (RAI) Coordinator #108 confirmed that both coding were correct as documented. During an interview, registered staff #109 confirmed that a continence assessment was not completed with the resident's change of status; and both staff confirmed that a continent assessment should have been completed.

During an interview, the home's Acting Director of Resident Care state that the expectation was for registered staff to complete a continent assessment at admission and re-admission to the home and with significant changes; therefore a continence assessment should have been completed for resident #005. [s. 51. (2) (a)]

3. During the Resident Quality Inspection (RQI) resident #004 triggered for Incontinence by the home Minimum Data Set – most recent assessment.

Record review revealed that on an identified date, the resident was coded as being in complete control of bowel and tended to be incontinent for bladder; and on another identified date, the resident was coded as occasionally incontinent for bowel and incontinent episodes once per week or less for bladder. During an interview, registered staff #111 confirmed that a continence assessment was not completed with the resident's change of status; and confirmed that an assessment should have been completed.

During an interview, the home's Acting Director of Resident Care state that the expectation was for registered staff to complete a continent assessment at admission and re-admission to the home and with significant changes; therefore a continence assessment should have been completed for resident #004. [s. 51. (2) (a)]

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 resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home.

The home's satisfaction survey was inspected after the inspector had learned during the Resident's Council interview that the satisfaction survey used by the home was based on Abaqis information included in stage one of the resident quality inspection (RQI).

A review of the home's current process for determining satisfaction involves the following:

- the use of a questionnaire similar to the stage one questions included in the Ministry of Health Resident Quality Inspection program plus two additional questions regarding the recommendation of Yee Hong Homes to other people;
- selection of residents with cognitive performance scale (CPS) score of zero, one, and two; therefore, in 2016, 44 residents were selected and 30 residents were selected in 2017. As a result, residents from the second floor North and second floor south units were not selected in the sample surveyed in 2016; and a sample of one resident was selected from the second floor North and South units in 2017, and;
- volunteer trained at the corporate office, would complete the questionnaires with the selected residents in one of the common area of the home.

During interviews, Activation Manager #130 and A-DRC #128 acknowledged that the process in place to complete the annual resident satisfaction survey within the home is an audit and does not measure satisfaction with care, service, and programs offered in the home such as occupational therapy, physiotherapy, foot care, dental care, behavior program, restorative program, and the skin and wound program. [s. 85. (1)]

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 at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years were posted and communicated.

On an identified date while conducting the initial tour in the home the inspector observed that inspection report #2017_235507_0001 was not posted in the home. During an interview, the Acting Executive Director #113 confirmed the missing report should have been posted. Prior to exiting the home the inspector observed that the report was posted in the home. [s. 79. (3) (k)]

Issued on this 14th day of November, 2017

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

Original report signed by the inspector.