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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 5, 2020	2020_838760_0014	024524-19, 024525-19, 004059-20, 009598-20, 010214-20, 011068-20	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 Finch
60 Scottfield Drive SCARBOROUGH ON M1S 5T7

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

JACK SHI (760)

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): July 23, 24, 27, 28, 29, 30, 31, 2020

Log #004059-20, CIS #2934-000007-20 related to falls prevention;
Log #009598-20, CIS #2934-000010-20 related to falls prevention;
Log #010214-20, CIS #2934-000012-20 related to falls prevention;
Log #011068-20, CIS #2934-000013-20 related to an unexpected death;

Log #024524-19 follow up to Compliance Order (CO) #001, s. 19. (1), related to prevention of abuse and neglect, issued under inspection #2019_595110_0011, on December 12, 2019, with a compliance due date of February 28, 2020, was inspected;

Log #024525-19 follow up to CO #002, r. 107. (3), related to reporting critical incidents to the Director, issued under inspection #2019_595110_0011, on December 12, 2019, with a compliance due date of February 28, 2020, was inspected.

During the course of the inspection, the inspector reviewed records, interviewed staff and conducted observations.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Associate Director of Resident Care (ADRC) and Director of Resident Care (DRC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 107. (3)	CO #002	2019_595110_0011	760
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_595110_0011	760

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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan for the resident was based on an assessment of the resident's risk behaviours by the Behavioural Supports Ontario (BSO) team.

A Critical Incident System (CIS) report was submitted by the home related to a fall resident #003 and resulted in the hospitalization of the resident and a change in their condition.

A record review of the resident's progress notes indicated, they sustained a number of recent falls, mainly from an identified action that resident #003 performs. In addition, progress notes indicated resident #003 had recently been demonstrating a number of responsive behaviours that resulted an increase risk of falling.

A record review of the resident's chart did not indicate that the BSO team assessed resident #003 and were not involved in the development of their fall prevention interventions, despite documentation from the registered staff, indicating that resident #003 had a specific identified responsive behaviour that contributed to them falling.

An interview with RPN #113 confirmed that resident #003 has an identified responsive behaviour that increases their risk of falling and sustained a number of falls after they had were hospitalized and returned to the home.

RPN #114 was interviewed confirmed that resident #003 also identified responsive behaviours that contributes to their risk of falling. RPN #114 stated that an assessment from the BSO team would be helpful for resident #003 with the development of their fall prevention interventions. An interview with PSW #116 also supported that resident #003 would benefit from the involvement of the home's BSO team.

An interview with BSO RPN #112 indicated that if they were involved in a resident with identified responsive behaviours that increased their risk of falling, they would try have involve non-pharmacological interventions first and then potentially referring the resident to psychiatric resources for pharmacological interventions, if the non-pharmacological interventions were not effective. BSO RPN #112 did not recall conducting an assessment on resident #003 in the development of their fall prevention interventions and indicated if they were involved, they would produce both pharmacological and non-pharmacological interventions to reduce their risk of falls.

ADRC #117 was interviewed and indicated that BSO staff would be helpful at supporting staff in assessing whether a resident's responsive behaviours or unmet needs contributed to their falls. ADRC #117 indicated that if staff referred resident #003 to the BSO team, they would be able to assess what the resident's needs are and help the nursing team further as it relates to developing fall prevention interventions for resident #003. ADRC #117 confirmed that the BSO team was not involved in resident #003's care, as they did not receive a referral from the staff to conduct an assessment on resident #003.

The home failed to ensure that the BSO staff conducted an assessment in resident #003's plan of care based on their responsive behavioural needs that contributed to their falls. [s. 6. (2)]

2. The licensee failed to ensure that resident #004's plan of care was followed in relation to their fall prevention interventions.

A CIS report was submitted by the home, related to a fall that resident #004 sustained and resulted in their hospitalization and a significant change. The home submitted a second CIS report where resident #004 sustained another fall and had to be hospitalized and had a significant change in their condition.

A record review of the progress notes indicated that between those two falls that resulted in resident #004's hospitalization, they sustained a number of falls with no injuries. In one of those falls, it was documented that resident #004's fall prevention intervention was not in place and staff heard the resident call for help and noticed the resident sustained a fall at that time.

A record review of resident #004's written plan of care indicated that the identified fall

prevention intervention was part of their plan of care.

An interview with RPN #119 indicated that they responded to the incident and that the documentation they put in resident #004's progress notes was incorrect. RPN #119 indicated that resident #004 had a staff member present at that time with the resident and therefore, the fall prevention intervention was not being used, while the resident was in their room. When RPN #119 asked the staff member what had happened, they indicated that they had stepped out to get something for a minute and then the resident had a fall in between the minute that they stepped out for. RPN #119 stated that the fall prevention intervention should have been in place when the staff member left the room.

An interview with PT #103 indicated that their expectations would be that if resident #004 was left alone, the fall prevention intervention should have been in place, but they could not comment on this specific situation as they were not informed of what transpired in the events that lead to this resident's fall.

DRC #105 was interviewed and indicated that they would expect the fall prevention intervention to be in place if the staff member left the resident's room. DRC #105 confirmed that the identified fall prevention intervention was a part of resident #004's plan of care. DRC #105 confirmed that the home did not follow resident #004's plan of care when staff failed to ensure that an identified fall prevention intervention, which was part of their plan of care, was in place when the staff left resident #004's room. [s. 6. (7)]

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 is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policies, that the policy was complied with.

In accordance with Ontario Regulation 79/10 s. 230 (4) (1) (v), every licensee of a long-term care home shall ensure that the emergency plans provide for medical emergencies.

A review of the licensee's policy, titled "Administration of CPR to a Resident: Nursing Responsibilities" (CNU-V-32), last updated April 2016, indicated that once two staff members are administering CPR, the RN/RPN will facilitate the transfer of care to the emergency medical staff (EMS), for a transfer to the hospital. Furthermore, a review of the licensee's policy, titled "RN/RPN Pronouncing Death" (CNU-V-34), last updated September 2019, indicated that RN/RPNs can pronounce resident death only if the death is expected.

A CIS report was submitted by the home related to an unexpected death of resident #005.

A review of the progress notes indicated that staff noticed that resident #005 had a change in their condition and required interventions to be administered. Eventually, RN #120 pronounced resident #005 to be deceased after interventions were rendered on the resident.

An interview with RN #120 indicated that they were trained to perform CPR every year and that according to the home's policy, only a doctor could pronounce an unexpected death of a resident. RN #120 confirmed that they determined that the CPR would stop on

resident #005.

DRC #105 was interviewed and indicated staff are trained annually to respond to emergency situations, such as code blues and providing CPR to residents. DRC #105 confirmed that the home's policy indicated that only a nurse practitioner (NP) or doctor can pronounce an unexpected resident death at the home. Furthermore, DRC #105 stated if CPR was being performed on a resident at the home, it is not to be stopped unless EMS arrives or if a doctor determines a resident to be deceased and not to further proceed with CPR interventions.

DRC #105 confirmed that RN #120 did not follow the home's policy.

The home failed to ensure that its policy, "RN/RPN Pronouncing Death" (CNU-V-34) and "Administration of CPR to a Resident: Nursing Responsibilities" (CNU-V-32) was complied with when a registered staff stopped CPR on resident #005 and declared them to be deceased. [s. 8. (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to resident #005 in the home unless the drug has been prescribed for the resident.

A CIS report was submitted by the home related to an unexpected death of resident #005 on May 24, 2020. A review of the CIS report indicated that a code blue was called for resident #005 and oxygen was provided to them at an identified amount.

A review of the home's policy, "Oxygen Therapy Coverage: Nursing Responsibilities" (CNU-VIII-02), last updated April 2019, did not provide information on the administration of oxygen to a resident during an emergency situation.

DRC #105 indicated in their interview that the home did not have a policy on the administration of oxygen during an emergency situation and that oxygen was to be considered a medication order.

A review of the progress notes indicated that RN #120 provided oxygen at an identified amount after assessing resident #005 to have a change in their condition.

A review of resident #005's health record indicated that they had a doctors order for a specified dose of oxygen. There was no order for the different amount that was administered by RN #120.

An interview with RPN #123 indicated that registered staff can administer a smaller amount of oxygen as per the medical directives signed by the physician. RPN #123 confirmed that oxygen was administered to resident #005 and that RN #120 was responsible for providing oxygen but could not recall if RN #120 received an order from the physician to administer the higher amount of oxygen to resident #005. RPN #123 stated that they cannot administer a higher amount of oxygen to a resident during emergency situations without receiving a telephone order from the physician.

RN #120 was interviewed and stated that they can provide a smaller amount of oxygen to a resident without a physician's order as per the home's policy. RN #120 confirmed that they provided a higher amount of oxygen to resident #005. RN #120 further stated that they believed the home had a directive for registered staff to provide this higher amount of oxygen to residents without the need of getting a physician's order, and thus they did not need to get one in resident #005's situation.

DRC #105 was interviewed and stated that the home does not have a directive for registered staff to provide a higher amount of oxygen to residents during an emergency situation. DRC #105 stated that staff should be able to provide oxygen therapy to the resident before calling the doctor as per the registered staff's assessment of a resident, during an emergency situation but should call the physician for an order after the oxygen therapy has been started or completed. DRC #105 confirmed that a higher amount of oxygen was administered to resident #005 and a physician order was not obtained during or after this incident. [s. 131. (1)]

2. Resident #006 was selected for sample expansion related to non-compliance identified with resident #005.

A CIS report was submitted by the home related to resident #006's unexpected death.

A review of the progress notes indicated that resident #006 was found by RPN #125 had a change in their condition and required oxygen. Oxygen was applied a higher identified amount.

A review of resident #006's chart indicated they had a physician order to provide oxygen at a lower amount, if their oxygen levels went down to an identified level.

An interview with RPN #125 indicated that in order to determine if a resident receives oxygen, they would need to assess the resident first. If the resident requires oxygen, RPN #125 stated they would review the resident's physician orders including any medical directives on providing oxygen to the resident. RPN #125 stated that if they needed to provide a resident with oxygen at a higher amount, they would need a physician order.

RPN #125 further stated in their interview that upon their assessment of resident #006's oxygen levels, they determined that if they provided the amount of oxygen they could receive, as per the physician's order, it would not be effective and the resident required more than that. RPN #125 stated they did call the physician to inform them of the situation and resident #006's condition, but forgot to ask them for an order to provide a higher level of oxygen to resident #006.

An interview with DRC #105 confirmed that resident #006 had a physician order to provide a lower amount of oxygen. DRC #105 confirmed that resident #006 had received a higher amount of oxygen from the registered staff but could not provide an order from

the physician related to this intervention.

The home failed to ensure that a physician's order was received, for registered staff to administered a higher amount of oxygen, which is considered a drug, for resident #005 and resident #006. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed immediately of an unexpected death of resident #005.

A CIS report was submitted by the home related to an unexpected death of resident #005 on an identified date. A record review of the CIS report indicated that it was submitted a period of time after the identified date of resident #005's unexpected death.

The CIS report indicated that the Ministry of Long-Term Care (MLTC) after hours line was not contacted related to this incident.

An interview with DRC #105 confirmed that the MLTC after hours line was not contacted about this incident and that the home did not follow the required reporting guidelines, in this situation.

The home failed to ensure that the Director was immediately informed related to the unexpected death of resident #005. [s. 107. (1) 2.]

Issued on this 6th day of August, 2020

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

Original report signed by the inspector.