Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: April 2, 2024	
Inspection Number: 2024-1418-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Yee Hong Centre for Geriatric Care	
Long Term Care Home and City: Yee Hong Centre - Scarborough Finch, Scarborough	
Lead Inspector Nicole Lemieux (721709)	**Inspector Digital Signature**
Additional Inspector(s) Vernon Abellera (741751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 26 to 29, 2024 and March 1, and 4 to 6, 2024.

The following intake(s) were inspected:

- One intake related to a Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (a)
Menu planning

77. (4) The licensee shall ensure that each resident is offered a minimum of,

(a) three meals daily.

The licensee failed to ensure that a resident was offered a minimum of three meals daily.

Rationale and Summary

During an observation of a dining area, a resident's drink and nutritional supplements were placed on their table, but food was not served to the resident. The entire lunch mealtime was observed by the Inspector.

The resident's written care plan indicated that a specific food portion should be offered to the resident along with other nutritional supplements at all meals.

A Food Service Worker (FSW) confirmed that they did not provide any food during the observation period to the resident.

The Registered Dietitian (RD) confirmed that the resident preferred the nutritional supplements instead of the food portion. The RD further confirmed that the resident was experiencing a medical condition which was why they received a specific food portion at all meals. The RD acknowledged that the resident should be offered food at each meal.

Failure to ensure that the resident was offered a minimum of three meals daily may exacerbate residents' existing health issues.

Sources: Observations, a resident's care plan, resident's diet list, and interviews with the FSW and RD. [741751]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee failed to ensure that two residents were not served a meal until staff were available to provide the residents with the required feeding support.

Rationale and Summary

During an observation of a dining area, two residents were served their drinks and meals without staff present to provide feeding support. Both resident's lunch trays were observed to be sitting on the table for several minutes, during which time the

resident's were not provided with feeding support. Both residents required feeding assistance as outlined in their plan of care.

In the Long-Term Care Home's (LTCH) directive, it stated that "Any resident requiring assistance with eating or drinking is not served a meal until assistance is available."

The Executive Director (ED) confirmed that the resident's food should not sit on the table for more than five minutes without staff available to provide feeding support. The Food Services Manager (FSM) confirmed that the expectation was that a resident's meal was not left to sit for more than five minutes, as after that length of time, the food would no longer be consumed at the intended temperature.

Failure to ensure that both residents were not served a meal until there was sufficient staff to provide the required support decreased the enjoyment of the dining experience and increased the potential risk of food contamination.

Sources: Observations, two resident's care plan, interviews with ED and FSM, and directive titled Best Practices for Promoting Safe Feeding (Appendix A). [741751]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing

practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee failed to ensure that procedures were implemented for the cleaning and disinfection of resident care equipment, specifically the vital signs machine.

Rationale and Summary

During observations, a Personal Support Worker (PSW) was noted to be taking a blood pressure reading of a resident in the activity room. The PSW was observed to complete the blood pressure reading, exited the activity room with the vital signs machine and placed it back in the nursing station. The PSW then left the nursing station without disinfecting the vital signs machine. The Inspector remained in place for several minutes for observation and noted no staff member returned to clean the vitals machine. The PSW confirmed they did not clean the vital signs machine after use. A Registered Practical Nurse (RPN) and the Infection Prevention and Control (IPAC) Manager confirmed that all resident care equipment, including the vital signs machine, should be cleaned after each use.

Failing to clean equipment in between resident use increased the risk of transmission of infections between residents.

Sources: Observations, and interviews with a PSW, RPN and the IPAC Manager. [721709]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to ensure that the IPAC standard issued by the Director was followed related to hand hygiene.

In accordance with the IPAC Standard for LTCH's issued by the Director, updated September 2023, section 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

During an initial tour of the home, several wall pumps and individual bottles of ABHR were observed to be expired. These expired ABHR hand hygiene agents were noted in several areas and floors throughout the home including inside and outside of resident's rooms for resident, staff and visitor use. The expiry dates on the ABHR hand hygiene agents ranged from various months of various years.

The IPAC Manager confirmed that expired ABHR were no longer effective as a disinfectant as per the manufacturer's recommendations.

Due to the home using expired hand hygiene agents, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents.

Sources: Observations, and interview with the IPAC Manager. [721709]

2) The licensee has failed to ensure that the IPAC standard issued by the Director was followed related to routine practices, specifically the four moments of hand hygiene.

In accordance with the IPAC Standard for LTCH's issued by the Director, updated September 2023, section 9.1 (b) states that the licensee shall ensure that routine

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practices are followed in the IPAC program, specifically hand hygiene, including but not limited to, the four moments of hand hygiene.

Rationale and Summary

Observations were conducted of a meal service in a dining room during the inspection. Multiple observations were made of a PSW not completing hand hygiene in between several residents and completing multiple various tasks. The PSW acknowledged they did not complete hand hygiene as per routine practices including the four moments of hand hygiene.

Both an RPN and the IPAC Manager confirmed that it was the expectation of the home that staff complete hand hygiene in between tasks as per routine practices and the four moments of hand hygiene.

Failure to complete hand hygiene during, but not limited to, the four moments of hand hygiene may result in further spread of infectious diseases.

Sources: Observations, and interviews with a PSW, RPN and the IPAC Manager. [721709]

3) The licensee has failed to ensure that the IPAC standard issued by the Director was followed related to additional precautions, specifically contact precautions.

In accordance with the IPAC Standard for LTCH's issued by the Director, updated September 2023, section 9.1 (e) states that the licensee shall ensure that additional precautions, are followed in the IPAC program, specifically that point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary

On initial tour of the home, the Inspector observed that signage for contact precautions was not posted on the door of a resident's room. A subsequent observation of the same room confirmed that the signage continued to not be in

place. The list provided by the home of all residents on additional precautions confirmed that the room was to have additional precautions in place. A Registered Nurse (RN) confirmed that the resident in room the identified room was to be on additional precautions and that the signage should be placed on the resident's door.

The IPAC Manager confirmed the resident in the above room was under additional precautions and the signage should have been placed on the door.

Failure to ensure the appropriate signage was placed at the point-of-care indicating enhanced IPAC control measures may result in further spread of infectious diseases.

Sources: Observations, the Home's updated Line List and interviews with an RN and the IPAC Manager. [721709]