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

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

# Public Report

**Report Issue Date:** May 1, 2025

**Inspection Number:** 2025-1418-0004

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Yee Hong Centre for Geriatric Care

**Long Term Care Home and City:** Yee Hong Centre - Scarborough Finch, Scarborough

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22 - 25, 29 - 30, and May 1, 2025.

The following intake(s) were inspected:
- An intake and a Critical Incident (CI) related to a resident's fall with injury.
- An intake related to a resident's care and services, nutritional support, responsive behavior, and falls.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

## INSPECTION RESULTS

## WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 34 (2)**
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee shall ensure that any actions taken with respect to residents #001, and #002 under a program, including the residents' assessments, reassessments, and intervention response was documented.

1. A review of resident #002's electronic care plan directed staff to apply a device on the resident when sitting on an identified surface. A Personal Support Worker (PSW) had assisted with transferring the resident from one surface to another after care was provided. While the staff had attempted to apply the device, the resident had refused its application and instructed the staff to leave their area while they continued with their personal care in the room. The PSW returned to the room at a later time and the resident was then found on the floor. The resident's refusal of the use of the device was never documented in the resident's electronic health records.

**Sources:** Resident #002's electronic health records, home's internal investigative notes, and staff interviews with the PSW and an Assistant Director of Care (ADRC).

2. Resident #001 had experienced a fall on an identified date. The home's policy on falls prevention and management directed the nurse to document the resident's post-fall condition every shift for three days. When reviewing the resident's electronic health records, their condition was not documented on three shifts during the three-day period.

**Sources:** Resident #001's electronic health records, and home's policy on falls prevention and management program.

## 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 (1)**

Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the use of equipment.

The resident's electronic care plan indicated that an intervention was to be worn at all times. An observation was made where the intervention was not applied on the resident because it was sent for cleaning as per the PSW.

**Sources:** Resident's electronic care plan and progress note, observation, and interview with the PSW.

## WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure the resident received a skin assessment using a clinically appropriate assessment instrument designed for skin and wound assessment when the resident exhibited altered skin integrity.

The resident had returned to the long-term care (LTC) facility with altered skin integrity. The home's policy on skin care and wound management program directed the staff to complete a Skin and Wound Assessment in the

resident's electronic health record. Such assessment tool was not completed for the resident on that date.

**Sources:** Resident's electronic health records, home's policy on skin care and wound management program, and staff interview with the Assistant Director of Care and Skin and Wound Care Coordinator.

## WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)**
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that the resident was reassessed at least weekly when they exhibited altered skin integrity.

The resident had returned to the LTC facility with altered skin integrity. The home's policy on skin care and wound management program directed the staff to complete a Skin and Wound Assessment in the resident's electronic health record on a weekly basis. The required assessment tool was not completed a week after they returned to the LTC.

**Sources:** Resident's electronic health records, home's policy on skin care and wound management program, and staff interview with the Assistant Director of Care and Skin and Wound Care Coordinator.

## WRITTEN NOTIFICATION: Responsive behaviors

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)**
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee shall ensure that actions taken to respond to the need of the resident, including assessment, was documented.

A review of the resident's electronic health records indicated that a behavior tracking form was to be completed with the purpose of monitoring the resident's behavior during a specified time period. When reviewed, multiple sections of the form were not charted as required.

**Sources:** Resident's health records, and staff interview with the Behavioral Supports Ontario Registered Nurse (BSO RN).

## WRITTEN NOTIFICATION: CMOH and MOH.

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 272**
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) were followed by the home in relation to alcohol-based hand rub (ABHR). Specifically, ABHR must not be expired as required by 3.1 Infection Prevention and Control (IPAC) Measures under Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

Four expired ABHR were found on two Resident Home Areas (RHAs) during an initial tour of the home.

**Sources:** Initial tour of the home, and interview with the IPAC Manager.

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

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