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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2014	2014_205129_0020	H-000904-13	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 - MISSISSAUGA
5510 Mavis Road, MISSISSAUGA, ON, L5V-2X5

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

PHYLLIS HILTZ-BONTJE (129)

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): September 23 and 24, 2014

During the course of the inspection, the inspector(s) spoke with registered and unregulated nursing staff, the Assistant Director of Care, the Director of Care and the Executive Director.

During the course of the inspection, the inspector(s) reviewed clinical records, reviewed the home's investigative notes and reviewed the home's policies and procedures related to Prevention of Abuse.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's right to be protected from abuse was fully respected and promoted, in relation to the following: [3(1)2]
Resident #001's right to be protected from abuse was not full respected and promoted when on an identified date in 2013 the resident was struck by co-resident #002. Clinical records indicated that resident #001 sustained a soft tissue injury; the resident subsequently complained of pain in the area of the injury and was assessed by a Nurse practitioner two days following the incident. Clinical records indicated that resident #001 was very upset and shocked at being struck, expressed fear of resident #002, ate meals in their room or was accompanied to the dining room with family for 5 days following the incident and demonstrated a decrease in food consumption. Resident #002 was known to staff to demonstrate aggressive responsive behaviours towards co-residents and staff. [s. 3. (1) 2.]

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 and ensuring the residents right to be protected from abuse is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with, in relation to the following: 20(1) Staff did not comply with the home's policy [Duty to Report] identified as CAD-IX-26 and last reviewed in October 2013. This policy identified that everyone, other than a resident, has a duty to report abuse of a resident by anyone immediately to the responsible Director at the Ministry of Health and Long Term Care. Staff did not comply with this direction when the home notified the Director through the submission of a Critical Incident Report which identified that a resident had been abused by co-resident in excess of two days after the incident occurred. [s. 20. (1)]

2. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents dealt with the requirement contained in O. Reg. 79/10 s. 104(h) related to reporting the outcome of an investigation concerning resident abuse, in relation to the following: [20(2)(h)]
The home's policy [Zero tolerance of Abuse] identified as CAD-VII-08 and last revised in July 2014 does not deal with the requirement under O. Reg. 79/10 s. 104(2) to report the results of the homes investigation of abuse of a resident to the Director within 10 days of becoming aware of the incident.
- The policy directed that the Division Head shall complete the investigation of any reported abuse within one month of the initial report and forward a final copy to the MOHLTC that outlines the findings of the investigation and corrective actions taken to date. [s. 20. (2) (h)]

Issued on this 6th day of October, 2014

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