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
Oct 13, 2017	2017_544527_0012	023203-17	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 - MISSISSAUGA
5510 Mavis Road MISSISSAUGA ON L5V 2X5

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

KATHLEEN MILLAR (527), HEATHER PRESTON (640), LEAH CURLE (585)

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 5, 10, 11, 12 and 13, 2017

The following Critical Incident (CI) and Complaint inspections were conducted concurrently with this RQI:

CI # 016437-16 related to resident to resident abuse; and
Complaint #009835-17 related to staff to resident abuse and improper transferring

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Resident Care (DRC), the Assistant Director of Resident Care (ADRC), the Facility Manager, the registered dietitician (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeper, activity aide, the Family Council Co-Chair, the Residents' Council Chairman, residents and family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interactions, reviewed clinical records, meeting minutes, staff schedules, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible.

Resident #008 was exhibiting responsive behaviours towards resident #009 in May, 2016.
The resident's clinical record was reviewed and there were no behavioural triggers identified for resident #008 related to responsive behaviours. Resident #008 exhibited the same responsive behaviours towards resident #009 a second time and it was at this time that the behavioural triggers were identified.
The home's policy called "Responsive Behaviours", number CIP-I-06, and revised March 2014, was reviewed and it directed staff to document and share with the interprofessional team the behavioural triggers, and the results of ongoing monitoring and investigation of behavioural triggers were to be documented in the resident's progress notes and care plan.
PSW #112 and RN #108 were interviewed and recalled the incident involving resident #008 towards resident #009 in May 2016. Both the PSW and the RN were unable to identify what the behavioural triggers for resident #008, and they were unable to provide any documentation related to the analysis and/or discussions related to behavioural triggers.
The BSO RPN #116 was interviewed and confirmed that based on their assessments for responsive behaviours, that the behavioural triggers were expected to be documented in the progress notes and in resident #008's care plan. They also confirmed that this was not completed in May 2016, but was identified after the second incident of behaviours involving resident #008 towards resident #009.
The Executive Director (ED) was interviewed and confirmed that they were unable to locate any information related to behavioural triggers on the resident's clinical record and in discussion with their staff related to the May 2016 incident, and that staff were expected to document the behavioural triggers in the resident's progress notes and care plan according to their policy and procedures.
The home failed to ensure that resident #008's behavioural triggers were identified and communicated to the interdisciplinary team.

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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

Issued on this 13th day of October, 2017

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

Original report signed by the inspector.