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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2020	2020_650565_0006	002473-20, 002532-20, 002580-20, 008550-20	Complaint

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

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 25, 26, July 2, 6, 8, 10, and 13, 2020, as an off-site inspection.

During the course of the inspection, the following intake logs were inspected:
- Complaint intake logs #002473-20 and #008550-20 related to falls prevention and nutrition care,
- Complaint intake log #002580-20 related to prevention of abuse, and
- Critical Incident System (CIS) intake log #002532-20 for CIS report # 2920-000001-20 related to falls prevention associated with complaint intake log #002473-20.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and Family Member.

The inspector conducted record review of resident's clinical records, and the home’s complaint and investigation records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint concerning the care of resident #002 was forwarded to the Director immediately.

A complaint received by the Ministry of Long Term Care (MLTC) revealed resident #002 sustained a identified injury on an identified date, and the complainant was concerned that the home had not found out the cause of the injury.

Review of the home's records indicated an identified email complaint was sent to ADRC #108 concerning how the resident sustained the injury and how they were provided with a specified care. The email was sent to ADRC #108 on an identified date and no record indicating it was forwarded to the Director.

Interview with ADRC #108 indicated they received the above-mentioned email complaint on the identified date. They spoke with the sender of the email on the same day and told them they will initiate an investigation. The ADRC confirmed the home had not forwarded the email complaint to the Director as required. [s. 22. (1)]

Issued on this 17th day of July, 2020

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

Original report signed by the inspector.