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

Hamilton District
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Public Report

Report Issue Date: January 16, 2025
Inspection Number: 2025-1404-0001
Inspection Type: Critical Incident
Licensee: Yee Hong Centre for Geriatric Care
Long Term Care Home and City: Yee Hong Centre - Mississauga, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6- 10, 13-16, 2025.

The following intakes were inspected:

- Intake: #00124756/ Critical Incident (CI) #2920-000014-24 was related to resident-to-resident abuse.
- Intake: #00131229/ CI #2920-000017-24 was related to infection prevention and control.
- Intake: #00133229/ CI #2920-000019-24 was related to falls prevention and management.

The following intakes were completed in this inspection:

- Intake: #00122316/ CI #2920-000009-24 and Intake: #00123884/ CI #2920-000012-24 were related to falls prevention and management.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care for a resident was set out in the plan of care.

During the observation of a resident's room, an intervention was noted to be in place to meet the needs of a resident with responsive behaviours. Staff acknowledged that there was no documentation of this in resident's care plan.

By not documenting the use of an intervention in the care plan, staff may not be aware of its presence and function, which could hinder monitoring process.

Sources: Resident's clinical records, observation, Interview with staff.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident of the long-term care home from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On an identified date, a resident sustained injuries after being hit by another resident in their room.

Sources: CI report, home's internal investigation notes, resident's records, interview staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident has fallen, the resident is assessed regularly using a clinically appropriate assessment instrument that is specifically designed for falls. In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the Fall Prevention and Management Program policy of the long-term care home is to be complied with.

Specifically, the staff did not comply with the Falls Prevention and Management Program Policy of the LTCH on ensuring that the required assessment was

completed and documented on all required times for a resident post-fall.

Sources: Falls Prevention and Management Program Policy, resident's records, interview with staff.

WRITTEN NOTIFICATION: Minimizing of Restraints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 6.
Requirements relating to restraining by a physical device
s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

The licensee has failed to ensure that requirements relating to restraining of a resident by a physical device were met.

A resident was restrained by a physical device as part of their plan of care. Resident's records and staff indicated that the resident's condition was not reassessed for the effectiveness of the restrain as required for a certain time period.

Sources: Resident's records, interview with staff.

WRITTEN NOTIFICATION: Resident Records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that the resident's written record was kept up-to-date at all times.

Specifically, the staff failed to ensure that certain assessments conducted for a resident were reflected and documented in the resident's records at all times as required.

Sources: Resident's records.