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
May 21, 2013	2013_215123_0011	H-001090-12,H-000024-13	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

MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18, 19, 23, May 1, 2, 7, 8, 9, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Social Worker, Behavior Service Ontario staff, Registered Staff, Personal Support Workers, Program staff and Facilities staff, residents and family members.

During the course of the inspection, the inspector(s) reviewed the homes policies, reviewed the home's internal investigation reports, reviewed residents' records, inspected supplies, observed resident to resident interactions, observed resident to staff interactions.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The home's internal investigation report was reviewed and indicated that resident #005 was verbally abused by a family member of resident #001 in September, 2012. Resident #001 record reviewed and documentation indicated that the incident took place. The home's Associate Director of Care, Social Worker and Administrator interviewed and confirmed this information. [s. 19. (1)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The home's internal investigation report reviewed and indicated that resident #005 was verbally abused by visitor of resident #001 in September, 2012. The results of the home's investigation of the incident was not reported to the Director. The home's Executive Director was interviewed and confirms the incident was not reported to the Director. [s. 23. (2)]

Issued on this 21st day of May, 2013

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

M. GRAY