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**
**Direction de l'amélioration de la performance et de la conformité**

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


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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 |
|---|---|---|---|
| Aug 27, 2013 | 2013_207147_0015 | H-000441-13 | 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**

LALEH NEWELL (147)

## 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): August 15, 16 and 26, 2013

H-000441-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Staff, Personal Support Workers (PSW) and Case Manager from Halton Geriatric Mental Health Outreach Program.

During the course of the inspection, the inspector(s) reviewed residents clinical and electronic health records, home's internal investigation and home's policy related to responsive behaviours.

The following Inspection Protocols were used during this inspection:
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.)<br><br>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.<br><br>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 failed to ensure that every resident has the right to be protected from abuse.

Resident #101 had displayed increased responsive behaviours and history of conflict with other residents including resident #102. The home had implemented strategies to minimize these behaviours. However, interview with staff indicated that the resident's behaviours were unpredictable and therefore the staff were unable to identify any specific triggers that could lead to a responsive behaviour.

Resident #102 was not protected from abuse by resident #101. Review of the resident #101 progress notes, home internal investigation and interview with the DOC and registered staff confirmed that in August 2013, resident #101 physically assaulted resident #102, which resulted in resident #102 sustaining an injury. Subsequently, resident #101 was transferred to hospital for further evaluation and assessment related to the increased aggressive behaviours towards others. [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 to ensure that every resident has the right to be protected from abuse., to be implemented voluntarily.***

**Issued on this 29th day of August, 2013**

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