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
Jan 11, 2018	2018_578672_0001	023177-17	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 - SCARBOROUGH McNICOLL
2311 McNICOLL AVENUE SCARBOROUGH ON M1V 5L3

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

JENNIFER BATTEN (672), BAIYE OROCK (624)

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): January 2, 3, 4, 5, 8, 9,10, 2018

The following logs were inspected concurrently during this Resident Quality Inspection:

Log #000053-17 - Related to alleged staff to resident abuse
Log #004413-17 - Related to a complaint regarding alleged resident abuse
Log #016371-17 - Related to a resident fall with injury

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), volunteers, translators, residents, Substitute Decision Makers, and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 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 failed to ensure that a written complaint about the care of resident #025 was forwarded immediately to the Director.

Related to log #004413-17,

On a specified date, the Substitute Decision Maker (SDM) of resident #025 submitted a written complaint to the Director, regarding an allegation of abuse of the resident. A review of the submitted complaint letter indicated that a written complaint about the same incident had been submitted to the home approximately two months prior, via email to the Executive Director.

A review of the licensee's investigation records into the incident indicated that the written complaint was not forwarded to the Director until one day following receipt of the initial complaint.

During an interview with the Acting Executive Director, who was the DOC at the time of the incident, she indicated that the licensee's expectation was that when a written concern about the operation of the home or the care of a resident is received, the written complaint is to be forwarded immediately to the Director. [s. 22. (1)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that an allegation of abuse of resident #025 was immediately reported to the Director.

Related to Log #000053-17,

A Critical Incident Report (CIR) was submitted to the Director on a specified date and time. According to the submitted CIR, during the day prior, the personal companion of resident #025 reported to RN #119 an allegation of resident abuse. Later that same day, resident #025's family member raised concerns about the allegation of resident abuse to the Director of Care, and later in the evening, the resident's family member sent an email to the Executive Director (ED) alleging abuse of the resident. This allegation of abuse was not reported to the Director until the evening of the following day.

During separate interviews which were conducted with RN #119 and the acting Executive Director, who was the Director of Care at the time of the incident, both indicated that the licensee's expectation was that any allegation of resident abuse should be reported immediately to the Director. [s. 24. (1)]

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Issued on this 11th day of January, 2018

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

Original report signed by the inspector.