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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 13, 2020	2020_838760_0025	003890-20	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 - Scarborough McNicoll
2311 McNicoll Avenue SCARBOROUGH ON M1V 5L3

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

JACK SHI (760)

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): October 6, 7, 8, 2020.

The following intakes were completed in this complaint's inspection:

Log #003890-20 was related to an allegation of resident abuse.

NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, s. 19 (1) was identified in a concurrent inspection #2020_838760_0024 (Log # 011756-20, CIS report #2801-000006-20) and issued in this report.

A Critical Incident Systems inspection # 2020_838760_0024 was conducted concurrently with this complaints inspection.

During the course of the inspection, the inspector(s) spoke with the Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Associate Director of Resident Care (ADRC) and the Director of Resident Care (DRC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. 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 licensee failed to ensure that resident #003 was protected from physical abuse from another resident.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident.”

A complaint was received from the Substitute Decision Maker (SDM) of resident #003 related to an incident of resident to resident physical abuse. A review of the resident’s progress notes indicated that resident #003 was demonstrating responsive behaviours. After a period of time, the RN suddenly witnessed another resident hitting resident #003 and the RN intervened immediately to separate the two residents. The RN noticed resident #003 sustained an injury. The RN stated resident #003 told them after the incident that the other resident had caused their injury. There was actual harm to resident #003, as they sustained an injury after this incident.

Sources: Resident #003’s progress notes; A resident's progress notes; Home’s investigation notes; Interviews with the RN and other staff. [s. 19. (1)]

2. The licensee failed to ensure that resident #002 was protected from physical abuse from another resident.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report from the home regarding an incident of resident to resident physical abuse. A review of resident #002’s progress notes indicated that resident #002 had an interaction with another resident and both residents were pushing an object towards each other. Resident #002 then became unsteady and sustained a fall with an injury. The RN stated that the other resident caused resident #002 to become unsteady and sustain a fall with an injury. There was actual harm to resident #002, as they sustained an injury after this incident.

Sources: Resident #002’s progress notes; A resident's progress notes; Home’s investigation notes; Interviews with the RN and other staff. [s. 19. (1)]

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 to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 13th day of October, 2020

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

Original report signed by the inspector.