Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
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Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2019	2019_659189_0013	010957-19	Critical Incident System

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

NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 25, 26, 27, 30, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake log was inspected:
Log #010957-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, Assistant Director of Resident Care, registered staff, personal support workers, residents and family members.

During the course of the inspection, the inspector conducted observations of resident to resident interactions, staff to resident interactions and provision of care, review of resident and home records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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 has failed to ensure that residents #001 and #002 were not neglected by

staff

Under O. Reg. 79/10, s. 5. for the purpose of the definition of "neglect" in subsection 5. of the Act, " neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long Term Care (MLTC) related to an incident of staff to resident neglect.

According to the CIS report, resident #001 called for assistance using the call bell multiple times. It was reported to the management that the PSW who was assigned to provide care to resident #001 did not provide assistance to the resident, however it was provided by another PSW. The home conducted an internal investigation into the incident and concluded that PSW #104 had failed to respond to resident #001 when they called for assistance.

A review of resident #001's plan of care identified the level of assistance that resident #001 required for the identified care need.

Interview with PSW #104 identified that on the date and time of this incident, they were unable to assist with resident #001's care needs due to an identified issue, and that they had informed PSW #106 that they would not be able to assist with the required care of resident #001. PSW #104 stated that they had informed the registered staff also that they would be unable to assist PSW #106 provide the required care to resident #001.

Interview with PSW #106 identified that on the date and time of this incident, resident #001 called for assistance multiple times. PSW #106 identified that they responded to the call bell and that the resident requested assistance with the identified care need. PSW #106 identified that when PSW #104 informed them that they would be unable to assist with providing resident #001's care, they attempted to find another staff to assist them, but were unable to find assistance. As a result, resident #001 did not receive the identified assistance until staff on the next shift arrived, which was approximately one hour later.

The inspector reviewed the detailed call bell activity report for resident #001. According to the call bell report, resident #001 pressed the call bell 11 times during the identified time

period. Interview with PSW #104 revealed that they responded to the call bell two to three times, the rest of the times, PSW #106 reported that responded to the call bell.

During interviews with the Director of Resident Care (DRC) and Assistant Director of Care (ADRC), they acknowledged that PSW #104 neglected to assist resident #001 by failing to provide them the assistance they required in a timely manner.

2. During the inspection period, the inspector identified areas of non compliance related to neglect of resident #001. An expanded resident sample inspection was conducted which identified that on an identified date, a family member of resident #002 reported to staff that upon arrival to the home they found one of the resident's identified fall prevention interventions was not in use and that the resident's call bell was not attached to the wall-mounted call bell system. Both interventions were included in resident #002's plan of care.

Interview with PSW #111 who worked on an identified date, revealed that resident #002 pushed the call bell multiple times requesting assistance with various care needs. PSW #111 stated that after providing resident #002 with all the requested care, the call bell continued to ring, so they disconnected the call bell by inserting an emergency plug into the system. This resulted in the call bell system, and the other identified safety system being inoperable. PSW #111 stated that they had intended to re-connect the proper systems at the end of their shift, but they had forgotten to do that.

PSW #111 identified that they had used this emergency plug system on a prior occasion to disarm a call bell system that they believed was not working properly.

A review of the home's policy titled "Nurse Call Management System: Nursing Responsibility" CNU-VIII-05, revised April 2019, stated when a malfunction is identified in the call system, the registered staff are to inform the facilities manager immediately, and inform the DRC/designate to discuss alternative measures available to facilitate prompt response to residents.

The inspector reviewed resident #002's detailed call bell report for the identified date and found that the resident activated the call bell twice on the shift. There were no further calls recorded prior to the disarming of the system by PSW #111.

The inspector reviewed the facilities maintenance log reports for a period of one year and

did not find any reports from staff that the call bells were not working, or that the staff had to use an emergency plug due to the call bell not functioning.

Interview with the DRC acknowledged that the disarming of the call bell and any other systems that rely on that connection is a serious issue. The
DRC confirmed the PSW staff did not follow the home's policy related to call bells, and systems should never be disarmed. And that any issues of system malfunction need to be reported as per the policy.

By disarming the call bell and other identified systems, resident #002 was prevented from being able to call for assistance. And the result of this action was that resident #002's care needs and safety were neglected.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189)
Inspection No. / No de l'inspection :	2019_659189_0013
Log No. / No de registre :	010957-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 16, 2019
Licensee / Titulaire de permis :	Yee Hong Centre for Geriatric Care 2311 McNicoll Avenue, SCARBOROUGH, ON, M1V-5L3
LTC Home / Foyer de SLD :	Yee Hong Centre - Mississauga 5510 Mavis Road, MISSISSAUGA, ON, L5V-2X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chau Nhieu-Vi

To Yee Hong Centre for Geriatric Care, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007

The licensee shall prepare, submit and implement a compliance plan outlining how the licensee will protect residents from abuse and neglect.

The compliance plan shall include but is not limited to the following elements:

1.Ensure that no device is used to stop residents' call bells from ringing.

2. Conduct audits on every shift to ensure compliance and maintain a record of all audit information including analysis and corrective action.

3. Retrain direct care staff to recognize that disabling the residents' call bell and not providing assistance with care constitutes abuse and neglect.

4. Maintain records of re-training, including who received the training, when it occurred, and the content of the training .

Grounds / Motifs :

1. The licensee has failed to ensure that residents #001 and #002 were not neglected by staff

Under O. Reg. 79/10, s. 5. for the purpose of the definition of "neglect" in subsection 5. of the Act, " neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

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Interview with PSW #104 identified that on the date and time of this incident, they were unable to assist with resident #001's care needs due to an identified issue, and that they had informed PSW #106 that they would not be able to assist with the required care of resident #001. PSW #104 stated that they had informed the registered staff also that they would be unable to assist PSW #106 provide the required care to resident #001.

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The inspector reviewed the detailed call bell activity report for resident #001. According to the call bell report, resident #001 pressed the call bell 11 times during the identified time period. Interview with PSW #104 revealed that they responded to the call bell two to three times, the rest of the times, PSW #106 reported that responded to the call bell.

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Director of Care (ADRC), they acknowledged that PSW #104 neglected to assist resident #001 by failing to provide them the assistance they required in a timely manner. (189)

2. During the inspection period, the inspector identified areas of non compliance related to neglect of resident #001. An expanded resident sample inspection was conducted which identified that on an identified date, a family member of resident #002 reported to staff that upon arrival to the home they found one of the resident's identified fall prevention interventions was not in use and that the resident's call bell was not attached to the wall-mounted call bell system. Both interventions were included in resident #002's plan of care.

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By disarming the call bell and other identified systems, resident #002 was prevented from being able to call for assistance. And the result of this action was that resident #002's care needs and safety were neglected.

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as level 2 pattern as it related to 2 out of 3 residents reviewed. Review of the home's compliance history revealed previous non compliance for s. 19 (1) under report 2017_370649_0003 . Due to the scope being patterned and severity as potential for actual harm, a compliance order is warranted. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 03, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

Service Area Office /
Bureau régional de services : Toronto Service Area Office