Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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# Original Public Report

**Report Issue Date:** March 26, 2024

**Inspection Number:** 2024-1404-0001

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Yee Hong Centre for Geriatric Care

**Long Term Care Home and City:** Yee Hong Centre - Mississauga, Mississauga

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Parminder Ghuman (706988) | Parminder Ghuman Digitally signed by Parminder Ghuman Date: 2024.03.27 13:39:08 -04'00' |

**Additional Inspector(s)**
Olive Nenzeko (C205)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-15, 18-19 & 21, 2024.

The following intake(s) were inspected:

- Intake: #00105392 - Critical Incident (CI) #2920-000009-23 - ARI - COVID – Outbreak declared 30DEC23 – Finalized 31JAN24 - 2N/2S/3S/4N/4S/5N/5S.
- Intake: #00107201 - IL-0122247-HA/IL-0122810-HA - Physical abuse to resident by another resident.
- Intake: #00107252 - IL-0122269-HA - Complainant has concerns regarding resident related to resident-to-resident physical/verbal abuse, and responsive behaviours. No trend identified.

- Intake: #00108656 - IL-0122886-HA - Alleged physical abuse to resident by another resident

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 24 (1)**

Duty to protect

s. 24 (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.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

**Rationale and Summary**

O. Reg. 246/22 s. 2 (1) (c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

On an identified date, a resident wandered into another resident's room and physically injured the resident. Staff were able to intervene and separated the residents.

Failing to protect a resident from physical abuse by another resident caused actual harm to the resident when they sustained physical injuries.

**Sources:** Interviews with Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC) and other staff, resident's clinical records, CI Report.

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## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident shall immediately report this suspicion to the Director.

**Rationale and Summary**

Critical Incident (CI) was reported on January 2, 2024, and the incident occurred on a previous identified date. The home was aware of this incident on a previous identified date. The Director of Resident Care acknowledged that this CI was not reported immediately.

A Resident sustained injuries and resident's family also had concerns about the safety of the residents. The DRC and Assistant Director of Resident Care (ADRC) has spoken about this incident to the family members, but CI was not submitted to the Director till January 2, 2024. The DRC has called the Infoline LTC Homes after hours line on a previous identified date, but CIS was not submitted till January 2, 2024.

Not reporting certain matters to the Director puts the residents at risk of harm for abuse of a resident.

**Sources:** CI Report, resident's progress notes and interviews with Director of Resident Care (DRC), Assistant Director of Resident Care (ADRC) and other staff.

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