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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 16, 2017	2016_432654_0009	032439-16	Complaint

Licensee/Titulaire de permis

UNIONVILLE HOME SOCIETY
4300 Highway #7 MARKHAM ON L3R 1L8

Long-Term Care Home/Foyer de soins de longue durée

UNION VILLA
4300 Highway #7 Unionville ON L3R 1L8

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

SIMAR KAUR (654)

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): November 18, 21, and 22, 2016.

During the course of inspection complaint intake #032439-16 was inspected.

During the course of inspection, the inspector observed meal service, related to resident care, reviewed resident records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Director of Care, Food Service Manager, Resident Assessment Instrument Minimum Data Set Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aids, Social Worker, and Residents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

The licensee has failed to ensure that each resident was offered a minimum of three meals daily.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC),

related to the provision of care for resident #001 including menu planning and dining service.

Record review of resident #001's progress notes for an identified month in 2016, indicated that resident #001 had not been going to the dining room for an identified meal service as per his/her choice. Further review of progress notes revealed that on multiple occasions the resident was upset about not getting the above mentioned identified meal, and instead getting a snack on a snack cart at an identified time.

Record review of resident #001's Point of Care Documentation (POC) indicated that the resident ate and drank zero percent for the identified meal on ten identified days in a specific identified month in 2016.

Interview with resident #001 indicated that he/she did not go to the dining room for the identified meal due to medical reasons for two weeks. Resident #003 further indicated that he/she was not provided with the identified meal between an identified period of time. Resident further indicated that he/she had received a snack instead of the identified meal service.

Interview with PSW #115 indicated that he/she served snacks to resident #001, and on five identified days during the identified snack cart service as mentioned above, he/she had provided resident with a snack. The resident refused to go to the dining room on an identified day, and he/she had not been provided with the tray service in his/her room.

Interview with PSW #109 indicated that during an identified shift on an identified date, resident #001 was not feeling well, and refused to go to the dining room for the identified meal. PSW further indicated that he/she had asked dietary staff #107 to make a tray service for resident #001, and dietary staff responded that the resident will get a snack at the identified snack cart. PSW confirmed that resident was not provided with the identified meal on the identified date.

Interview with RPN # 110 indicated that on another identified date resident #001 refused to get up for the identified meal service due to a medical reason. RPN further stated that he/she asked dietary staff #107 to make a tray service for the resident. The dietary staff indicated that a snack would be sent on the identified snack cart for the resident.

Interview with dietary aid #107 denied that he/she had refused to provide tray service for resident #001 to above mentioned staff.

Interview with the Food Service Manager (FSM) #111 indicated that the home uses a tray service requisition form for resident's who requires tray service. Staff member further confirmed that he/she had only two tray service requisitions for resident #001 on identified dates.

Interview with the DOC and FSM #111 indicated that as per home's expectation each resident is offered a minimum of three meals daily. DOC further confirmed that resident #001 had not been offered the identified meal on three identified dates.

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 each resident is offered a minimum of three meals daily, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to the provision of care for resident #001 including menu planning and dining service.

Record review of the resident #001's written plan of care indicated his/her identified preferences related to a specific identified provision of care. Further review of the plan of care indicated different identified preferences for resident #001 in a second section, which were opposite to the above mentioned preferences in the first section of his/her plan of care.

Interview with resident #001 indicated his/her specific preferences related to the provision of care as indicated in the second section of his/her written plan of care.

During observations on three identified dates, resident #001 was observed provided care as indicated in his/her written plan of care's second section.

Interview with the PSW #101, and RPN #104 confirmed that resident #001had been provided care as per his/her specific preferences related to the identified provision of care as mentioned in the second section of his/her written plan of care. The staff members further indicated that the resident's written plan of care was updated on an identified date, and it did not provide clear directions about the resident's specific preferences related to the specific provision of care.

During interview with the Resident Assessment indicator (RAI) Coordinator confirmed that he/she had updated resident #001's written plan of care on the above mentioned identified date, and had missed updating resident #001's specific preferences in all sections of his/her written plan of care.

Interview with the DOC indicated that resident's plan of care should set out clear directions to staff, and who provide care to the resident. He/she further acknowledged that resident #001 plan of care did not provide clear directions to the staff. [s. 6. (1) (c)]

The licensee has failed to ensure that resident was reassessed and the plan of care was

reviewed and revised at least every six months and at any other time when the resident’s care needs were changed and care set out in the plan was no longer necessary.

During a complaint inspection related to resident #001, the inspection sample was expanded, and resident #003 was inspected related to the plan of care.

Record review of the resident #003’s recent written plan of care, revised on an identified date, indicated that resident #003’s specific identified preferences related to provision of care.

Further record review of the resident #003’s progress notes indicated that the resident fell in the home on an identified date, and sustained an identified injury. He/she was admitted to the hospital for a treatment, and was readmitted to the home on another identified date.

Interview with PSW #114 indicated that resident #003 had the above mentioned injury in 2016, and the resident’s level for his/her activities of daily living had been changed. The PSW further indicated that the resident’s specific preferences related to the above mentioned provision of care had been changed since he/she had been back from the hospital. Interview with the resident’s assigned PSWs #115, #116 and dietary aid #107 confirmed that resident #003 had been provided care as per his/her new preferences related to the specific provision of care.

Interview with RPN #105/ RAI Coordinator confirmed that resident #003 was not reassessed and the plan of care was not reviewed and revised after his/her injury. RPN further confirmed that the plan of care did not indicate any change in resident #003's specific identified preferences related to the provision of care.

Interview with the DOC indicated as per home’s expectation resident is reassessed and the plan of care is reviewed and revised when the resident’s care needs are changed, and confirmed that resident #003’s plan of care had not been reviewed and revised as required.

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.