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
Jun 18, 2018	2018_578672_0007	017137-16	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

JENNIFER BATTEN (672)

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): March 28 and 29, 2018, and April 3 and 4, 2018

During the course of the inspection, the following logs were inspected:

Log#017137-16 - related to a complaint received by the home regarding a resident injury.

The inspector also observed staff to resident interactions, health care records, internal investigation notes, family meeting minutes, and internal policies and procedures.

During the course of the inspection, the inspector(s) spoke with The Chief Executive Officer (CEO), Administrator, Director of Care (DOC), receptionist, Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSWs), residents, volunteers, and families.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a documented record is kept in the home, related to a complaint from resident #003's daughter, which included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Related to Log #017137-16:

On a specified date, resident #003's family memeber forwarded a complaint to the Director, related to an injury, which was noted on a previous date, to resident #003's body part. The complainant included pictures of the area, and indicated that an internal investigation into the possible cause of the injury had not been undertaken by the home.

During record review, Inspector #672 noted that resident #003 received physiotherapy an identified number of times per week, which included a specified treatment.

On a specified date, resident #003's family member brought forward a complaint to the

nurse manager, related to an observation that resident #003 was noted to have an injury. Resident #003's daughter was unsure of the cause of the injury, and requested an investigation be initiated, due to concern it may have been related to the physiotherapy treatment resident #003 received.

During a record review, Inspector #672 observed on a specified date, the physiotherapist documented in resident #003's progress notes that a discussion with the physiotherapy assistant had taken place, and it was not believed that the cause of the injury was due to the specialized treatment. The complaint was forwarded to the DOC for further investigation.

Inspector #672 reviewed resident #003's progress notes from a specified date, to a specified date. Following the notation from the physiotherapist, there was a notation which indicated that a family meeting was to be held, to discuss the family member's complaints related to the care resident #003 was receiving, which included the cause of the injury.

Review of the minutes from the meeting were reviewed by Inspector #672. The minutes indicated that the injury was briefly discussed, and the DOC indicated a possible cause. The DOC then went on to other concerns the family had at the time, related to resident #003's care.

During an interview on a specified date, the Acting DOC indicated being unaware if an internal investigation had been conducted into the possible cause of the injury, due to not working in the role of DOC at the time of the incident, and could not recall what the previous DOC's actions had been.

During an interview on a specified date, the Administrator indicated being unaware if an internal investigation had been conducted into the possible cause of the injury, due to not being employed in the home at the time of the incident.

During the inspection, the Administrator and Acting DOC were both unable to locate any files related to documentation of an internal investigation into the possible cause of the injury to resident #003's body part; what action was taken in an attempt to prevent further injuries from occurring, including the date of the action or time frames for the action to be taken; what the final resolution of the complaint was (if any); any date on which a response had been provided to the complainant and a description of the response (if any); and any response made by the complainant. [s. 101. (2)]

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Issued on this 19th day of June, 2018

[redacted]

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

Original report signed by the inspector.