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
May 26, 2020	2020_838760_0007	007563-20, 007583-20	Critical Incident System

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

JACK SHI (760)

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): May 13, 2020- on site and May 14, 15, 19, 20, 2020- off site.

The following intakes were completed in this critical incident system inspection:
Log #007563-20,
Log #007583-20.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), York Regional Police Detective.

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

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

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan of care.

A Critical Incident System (CIS) report was submitted by the home related to a fall sustained by resident #002 with an injury and as a result, they were transferred to the hospital.

A record review of the resident's written plan of care at that time of the incident indicated resident #002 required two or more staff members during their baths.

A review of the progress notes indicated that RN #101 was called to assess resident #002 and saw PSW #112 attending to the injury resident #002 sustained. PSW #112 explained to RN #101 that while they turned their back to get the clothes for this resident after their shower, they slid from the chair and fell. RN #109 attended the situation afterwards and indicated in their documentation that they sustained an injury as a result of their fall. An assessment was conducted by RN #109 and an ambulance was called to send the resident to the hospital.

An interview with PSW #112 indicated resident #002 required two staff assistance during their baths, but they were alone at the time of this incident with the resident. PSW #112 indicated they turned their back away from the resident to grab supplies from the shower cart and resident #002 slipped and fell onto the floor as a result.

PSW #113 was interviewed and indicated they went to attend the situation after hearing PSW #112 ring the call bell from the shower room. PSW #113 indicated that there was visible injuries on resident #002 when they arrived in the shower room and called a nurse to attend the situation. PSW #113 confirmed that there was no second staff present to assist with resident #002's bath by PSW #112.

An interview with RN #109 stated resident #002 was assessed and sent to the hospital afterwards and their injuries have since healed.

DOC #100 confirmed that resident #002 required two staff assistance at all times during their baths as per their written plan of care and that there was no second staff present to assist during at the time of this incident.

The home failed to ensure resident #002's written plan of care was followed during their bath. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 #001 was protected from verbal and physical abuse by PSW #111.

A CIS report was submitted by the home related to an incident of staff to resident physical abuse. According to the CIS report, resident #001's SDM requested to speak with DOC #100 about an incident that was captured with a video camera in the resident's room. The SDM indicated that the approach and care of PSW #111 was not right.

Inspector #760 reviewed the video camera footage of this incident and observed PSW #111 verbally and physically abusing resident #001. The resident was observed to fall to the floor after an interaction with the staff member. The resident was visibly distressed by the actions of PSW #111.

A record review of the home's progress notes indicated the incident was reported to the registered staff by PSW #111. Interventions and actions were rendered to resident #001 by the registered staff members and as a result, they were sent to the hospital for further assessment.

Further review of the progress notes indicated that resident #001 was diagnosed with an

identified injury from their fall.

An interview with RPN #105 indicated they heard a loud noise coming from resident #001 room and came to assist afterwards and was told by PSW #111 that the resident almost had a fall and PSW #111 caught the resident before they fell. RPN #105 provided an assessment to resident #001 and noted they were very frightened by the situation.

RN #101 was interviewed and indicated they attended the resident and was told the same story as RPN #105 by PSW #111 about resident #001's "near miss fall". RN #101 provided interventions and received a verbal and written statement from PSW #111 at that time.

An interview with DOC #100 indicated that when they became aware of the incident, they assessed resident #001 and ordered the staff to have the resident transferred to the hospital for further assessment. DOC #100 indicated police became involved in the incident and eventually charged and arrested PSW #111.

The home failed to ensure resident #001 was protected from verbal and physical abuse from PSW #111.

These findings are further evidence to support the order issued on March 24, 2020, during critical incident system inspection #2020_643111_0007 to be complied July 31, 2020. [s. 19. (1)]

Issued on this 1st day of June, 2020

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

Original report signed by the inspector.