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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 22, 2020 | 2020_823653_0007 | 023151-19, 000727-20, 000817-20, 002391-20, 002485-20, 002798-20, 002799-20, 003081-20 | 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**

ROMELA VILLASPIR (653), LYNDA BROWN (111)

## 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): February 20, 21, 24, 25, 27, 28, March 2, and 3, 2020.**

**The following Complaint log intakes had been inspected:**

**-#023151-19 related to dietary plan of care;**
**-#000727-20 and #000817-20 related to allegation of abuse, continence care and bowel management, and falls prevention;**
**-#002391-20 related to allegation of abuse, bathing, nail care, physiotherapy services, recreational and social activities;**
**-#002485-20 and #002798-20 related to allegation of neglect, snack service, and responsive behaviours;**
**-#002799-20 related to dining service;**
**-#003081-20 related to monitoring, documentation, and treatment of chronic infections.**

**During the course of the inspection, the inspector conducted observations of resident care provision, resident interactions, reviewed the staff schedule, clinical health records, the home's investigation notes, and relevant home policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Maker (SDM), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Recreation Therapists (RTs), Dietary Aides (DAs), Dietary Manager (DM), and the Director of Care (DOC).**

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

**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Falls Prevention**
**Infection Prevention and Control**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Responsive Behaviours**
**Snack Observation**

**During the course of this inspection, Non-Compliances were issued.**

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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 has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to resident #003.

An anonymous complaint was received by the Director indicating resident #003 was not receiving an identified care.

A review of resident #003's written plan of care indicated they required assistance for their scheduled preferred baths, and for an identified care to be provided on bath days.

A review of the progress notes for resident #003 indicated the Physiotherapist (PT) recommended that the preferred baths were not appropriate for the resident and recommended the resident receive an alternative bath.

A review of the bathing list indicated resident #003 was assigned a schedule to receive the alternative bath.

A review of the Point of Care (POC) records indicated resident #003 received their scheduled baths per week. The records did not indicate which type of bathing the resident received.

During an interview, the Director of Care (DOC) indicated no awareness that the POC for resident #003 did not indicate which type of bathing the resident was being provided. The DOC confirmed the resident's bathing preference should be clear on the plan of care, staff bath list, and on the POC.

The licensee has failed to ensure that the written plan of care for resident #003 sets out clear directions to staff and others who provided direct care to the resident, related to bathing preferences. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #015 collaborated with each other in the implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint related to charting concerns on an identified Home Area (HA). The complainant indicated many residents were suffering from chronic infections and were being left too long before treatment. The complainant stated the symptoms were being overlooked, therefore, testing was not being done until residents become very ill.

The inspector reviewed the HA's infection surveillance sheet and identified resident #015 as one of the residents who received treatment for an identified infection.

A review of resident #015’s written plan of care indicated they required monitoring related to frequent infections and medical history. Under the interventions, it directed staff to assess, record, and report to the physician as needed for signs and symptoms of infection. It also indicated that resident #015 presented with an identified symptom when having an infection.

A review of resident #015’s progress notes from an identified period, indicated the resident received treatment for suspected infection.

Further review of resident #015’s progress notes from an identified period, indicated they presented with a symptom and treatment for suspected infection was started.

A review of resident #015's physician digiorder form indicated the physician discontinued the current treatment and started a new treatment. The physician also ordered two clinical lab tests to be done.

A review of resident #015's progress notes did not identify that a specimen was collected and sent for clinical lab test to be done.

An interview with RPN #110 indicated the collection of the specimen may have been delayed until the treatment was completed.

During an interview, the DOC acknowledged the above mentioned information, and further indicated that the expectation was for the registered staff to clarify the order with the physician. The DOC acknowledged that the staff and others involved in the different aspects of care of resident #015 did not collaborate with each other in the implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the written plan of care was provided to resident #006.

The MLTC received a complaint regarding resident #006 being served a food item they were known to be severely allergic to.

A review of resident #006's Point Click Care (PCC) profile under the "allergy" tab and written plan of care, indicated they were severely allergic to an identified food item.

An interview with PSW #125 indicated on an identified date, they served an identified food item to resident #006 during a meal service. The PSW further stated they did not check the dietary sheet at the servery and was not aware the resident was allergic to that particular food item.

An interview with Dietary Aide (DA) #122 indicated they were aware resident #006 was allergic to an identified food item, and that both the DAs and PSWs were supposed to check the dietary sheet in the servery area prior to serving meals. DA #122 indicated resident #006 did not consume the identified food item as their family member arrived in the dining room and returned the plate to the DA.

An interview with the Dietary Manager (DM) acknowledged the above mentioned incident and that care was not provided to resident #006 as specified in the plan when they were served a food item they were severely allergic to. [s. 6. (7)]

4. The MLTC received a complaint regarding resident #006's continence care not provided by staff in the home.

A review of resident #006's written plan of care indicated they required an identified care provision from staff for their continence care and bowel management.

During an observation conducted by Inspector #653, the resident did not receive the identified care provision from staff, as indicated on their written plan of care.

An interview with PSW #102 indicated they usually provided an identified assistance to resident #006 for continence care. The inspector and the PSW reviewed the resident's written plan of care and the PSW acknowledged that care was not provided to the resident as specified in the plan during the inspector's observation.

An interview with RPN #103 indicated the continence care required for resident #006, and further acknowledged that care was not provided to resident #006 as specified in the plan of care during Inspector #653's observation.

During an interview, the DOC and the inspector reviewed resident #006's written plan of care, and the DOC acknowledged continence care was not provided to the resident as specified in the plan during the inspector's above mentioned observation. [s. 6. (7)]

5. The MLTC received a complaint regarding resident #006's falls prevention interventions not being implemented by staff in the home.

A) A review of resident #006's written plan of care indicated they were at risk for falls and directed the staff to ensure that an identified falls intervention was in place when the resident was in bed.

An observation conducted by Inspector #653 in the resident's bedroom and an interview with PSW #101, indicated that the identified falls intervention was not in place when the resident was in bed.

During an interview, the DOC and the inspector reviewed resident #006's written plan of

care, and the DOC acknowledged care was not provided to the resident as specified in the plan related to falls prevention interventions, during the inspector’s above mentioned observation.

B) The home submitted a Critical Incident Report (CIR) to the Director for allegation of staff to resident abuse. The CIR indicated the DOC received a written complaint from resident #006's Substitute Decision-Maker (SDM), and one of the identified concerns was their falls intervention device was not working properly on an identified date.

A review of resident #006’s written plan of care indicated they were at risk for falls and were to have a falls intervention device in place when in bed. The staff were to ensure the device was working properly with every check, placed on resident's bed, and switched on when resident was in bed.

A review of resident #006’s Risk Management Module (RMM) report and an interview with Recreation Therapist (RT) #112 indicated on an identified date and time, the RT found the resident in their bedroom sitting on the floor by the bedside. The RT stated they were walking down the hallway when they saw the resident was on the floor. RT #112 confirmed they did not hear any device go off at the time of the incident.

An interview with RPN #103 indicated RT #112 notified them that resident #006 was on the floor. The RPN stated after attending to the resident, they checked the device and it was working, however, acknowledged that it did not go off at the time of the fall.

An interview with the DOC indicated based on their investigation, a part of the device was not properly connected or plugged at the time of the fall. The DOC further indicated that PSWs were supposed to check if the device was working and inform the registered staff of any problem. The DOC acknowledged that care was not provided to resident #006 as specified in the plan when the device did not go off at the time of the fall. [s. 6. (7)]

6. The MLTC received a complaint related to resident #006 sustaining an alteration in skin integrity from an unknown cause. The complainant indicated on an identified date, the family members who visited, noted an alteration in skin integrity on the resident. The complainant stated the family was not notified and there was no information on record about the resident's alteration in skin integrity.

A review of resident #006’s written plan of care indicated their bathing preference and

that they required an identified number of staff assistance.

A review of POC documentation on the day the family members visited, indicated an identified type of bath was provided to resident #006 with an identified number of staff assistance.

During an interview, PSW #126 and Inspector #653 reviewed their POC documentation for resident #006's Activities of Daily Living (ADL) – Bathing and the PSW acknowledged care was not provided to the resident as specified in the plan, related to the required number of staff assistance for bathing. The PSW also stated they did not notice any alteration in skin integrity on the resident at the time.

During an interview, the DOC and Inspector #653 reviewed PSW #126's POC documentation and the DOC acknowledged care was not provided to resident #006 as specified in the plan, related to the required number of staff assistance for bathing. The DOC further indicated it was the responsibility of the PSWs to review the resident's kardex prior to providing care. [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.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an equipment was maintained in a safe condition and in a good state of repair.

The MLTC received a complaint regarding resident #006's falls prevention interventions not being implemented by staff in the home.

A review of resident #006's written plan of care indicated they were at risk for falls and were to have a falls intervention device in place when in bed. The staff were to ensure the device was working properly with every check, placed on resident's bed, and switched on when resident was in bed.

A review of progress note on an identified date indicated PSW #101 found resident #006 on their bedroom floor, and one of the long-term actions taken to prevent re-occurrence was to change the device.

An interview with RPN #110 indicated when the PSW found the resident on their bedroom floor, the device did not go off. The RPN stated it was switched on, but when they tested it, the device was not working properly so they replaced it with a new one. RPN #110 acknowledged that in this case the equipment was not maintained in a safe condition and in a good state of repair.

During an interview, the DOC acknowledged the above mentioned information and indicated it was the responsibility of the PSWs to check the device to ensure they were working, and if the equipment was defective, the PSWs were to report to the RPN. [s. 15. (2) (c)]

2. As a result of identifying non-compliance related to the device not maintained in a safe condition and in a good state of repair, the sample size was expanded which included resident #014.

A review of resident #014's written plan of care indicated they were at risk for falls and one of the interventions was for the identified device to be applied.

During an observation in resident #014's bedroom, RPN #103 transferred the resident from the bed to their mobility aid, and the device did not sound off. Upon checking by Inspector #653 and the RPN, a large tear was noted on the device. The RPN acknowledged the device was not in a safe condition and in a good state of repair, and they would have it replaced right away.

A review of RPN #103's subsequent progress note indicated resident #014's device was replaced due to a rip.

During an interview, the inspector showed the DOC a photo of resident #014's device that was observed with a rip, and the DOC acknowledged it was not maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

***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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home had a snack service that included at a minimum the following elements: Providing resident #006 with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The MLTC received a complaint regarding a PSW who ate resident #006's snack before feeding the rest to the resident, as captured on video surveillance.

The home submitted a CIR to the Director related to allegation of neglect. The CIR indicated the DOC received an e-mail from resident #006's SDM regarding a video footage concern.

An interview with PSW #111 indicated at the time when they served resident #006's snack, they tasted the snack first to check if it was still good to give to the resident. The PSW acknowledged they were not supposed to eat the resident's food and that resident #006 was not provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

During an interview, the DOC indicated they had reviewed the video footage and had spoken to PSW #111 as part of their investigation. The DOC confirmed that the PSW ate resident #006's snack and fed them the leftover. The DOC acknowledged that resident #006 was not provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

***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 home has a dining and snack service that includes, at a minimum, the following elements: Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following rights of resident #006 were fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

An interview with PSW #111 indicated at the time when they served resident #006's snack, they tasted the snack first to check if it was still good to give to the resident. The PSW acknowledged they were not supposed to eat the resident's food and that resident #006's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity, was not respected and promoted.

During an interview, the DOC indicated they had reviewed the video footage and had spoken to PSW #111 as part of their investigation. The DOC confirmed that the PSW ate resident #006's snack and fed them the leftover. The DOC acknowledged that the PSW did not fully respect and promote the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity. [s. 3. (1) 1.]

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**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.**