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
Sep 24, 2020	2020_838760_0020	010591-20, 018618-20	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

JACK SHI (760)

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): September 16, 17, 21, 22, 2020.

The following intake was completed in this complaint inspection:

Log #015839-20 was related to responsive behaviours and medication;
Log #018618-20 was related to continence care and significant change in condition.

A CIS inspection # 2020_838760_0021 was conducted concurrently with this complaints inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and Personal Support Workers (PSWs).

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Responsive Behaviours

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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 was provided continence care, when they were found to be in a soiled condition by the staff.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding concerns related to the continence care of resident #002. The progress notes indicated that resident #002 was found in a soiled condition. The documentation further indicated that there was a notable time period of when the resident was last assisted with continence care. The PSW was interviewed and stated they did not want to bother the resident for care, as they were noted to be resting comfortably. The RPN stated there was no directions for staff to indicate that they should not bother the resident when they are resting comfortably and further indicated the resident was provided continence care after the RPN told the PSW to go check on the resident. The RPN stated that the PSW should have assisted the resident, prior to the RPN telling the PSW to do so and that the resident should not have been left in a soiled condition for that long.

Sources: Resident #002's care plan and progress notes; Interviews with PSW #101, PSW #102, RPN #103, Acting DOC #104 and other staff.

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, (g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed immediately related to the unexpected death of resident #002.

A complaint was received by the MLTC related to concerns around resident #002's death. The resident's progress notes indicated that they were found to have a significant change in their condition. The progress notes further indicated the resident was sent to the hospital and passed away there after being diagnosed with a medical condition. An incident report regarding this situation or a call to the Ministry's after-hours line was not found. Interviews with various staff members determined that the resident passed away unexpectedly. Acting DOC #104 verified that the Director was not informed regarding this incident.

Sources: Resident #002's progress notes; Critical incident reports submitted by the home; Interviews with RN #100, PSW #101, PSW #102, RPN #103, Acting DOC #104 and other staff. [s. 107. (1) 2.]

Issued on this 25th day of September, 2020

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

Original report signed by the inspector.