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 4, 2021	2021_882760_0013	005164-20, 025625-20, 001674-21	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): April 26, 27, 28, 29, 2021.

The following intakes were completed in this complaints inspection:

A follow up log to Compliance Order (CO) #001, LTCHA s. 19 (1), related to abuse and neglect, issued under inspection #2020_643111_0007, on July 29, 2020, with a compliance date of October 30, 2020, was inspected;
Two logs were related to falls and one log was related to a resident's change in condition.

A Critical Incident Systems inspection # 2021_784762_0011 was conducted concurrently with this Complaints inspection.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Agency Personal Support Workers (Agency PSW), Personal Support Workers (PSW), Director of Care (DOC), Chief Financial Officer (CFO), Administrator, Clinical Quality Educator (CQE) and the Chief Executive Officer (CEO).

During the course of the inspection, the inspectors observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_643111_0007	760

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 an RN performed an assessment on a resident, as specified in their plan of care.

A review of the camera footage showed that the resident had symptoms and the RN had came to assess the resident. The resident was reassessed by different nurses at a later period of time and interventions were rendered afterwards. In the resident's care plan, it states that a certain assessment was to be performed when the resident demonstrates specific signs and symptoms and further interventions were required after their assessment. A PSW indicated they had noticed the resident had a change in condition, which was why they asked the RN to assess the resident. The RN stated they did not provide further interventions to the resident after their assessment. The Clinical Quality Educator (CQE) confirmed the RN did not perform the required assessment from their care plan and should have followed up further with additional interventions afterwards. There was potential risk to the resident, as they may have benefited with further interventions provided earlier, if it was determined to have been necessary after the required assessment was performed on them.

Sources: Review of camera footage; the resident's care plan and progress notes; Interviews with a PSW, an RN, the CQE and other staff. [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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for a resident.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home’s policy and procedure "Falls Prevention and Management Policy", dated January 2019. The policy states that the registered staff are to assess a resident after a fall and the resident is not to be moved until that assessment occurs.

A review of the camera footage showed that the resident sustained a fall and that the agency PSW did not inform a registered staff. The agency PSW was then seen transferring the resident from the ground. The RPN stated that they were never informed of the resident’s fall. The RPN indicated they had suspected that the resident did have a fall, based on the symptoms they were experiencing. Clinical Quality Educator (CQE) confirmed that this agency PSW did not follow the home’s falls policy as it relates to informing the registered staff immediately after a resident falls and not moving the resident from the floor, prior to a registered staff assessing the resident. There was actual risk to the resident, as the failure to report a resident’s fall to the registered staff and transferring the resident after a fall without an assessment may have exacerbated their symptoms and led to further injuries.

Sources: The home’s investigation notes including the camera footage; The home’s fall prevention and management policy, dated January 2019; A resident’s progress notes; Interviews with an RPN, the CQE and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, and (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a pain assessment was performed on a resident using a clinically appropriate tool, when they demonstrated signs and symptoms of pain.

The home's pain management policy indicates that a pain assessment tool is used when the resident experiences pain. A review of the resident's progress notes indicated they had experienced symptoms of pain; however, a pain assessment was not completed. Clinical Quality Educator (CQE) confirmed that the home's pain assessment tool was not used when the resident had signs and symptoms of pain. There was potential risk to the resident, as the failure of conducting the pain assessment on the resident may lead to missed opportunities to implement further interventions to relieve their pain.

Sources: A resident's progress notes, documentation on their chart; Home's pain management policy, dated January 2019; Interview with the CQE and other staff. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that an agency PSW participated in the home's infection prevention and control (IPAC) program.

The home was in an outbreak during the course of the inspector's inspection at the home and a number of staff and visitors had tested positive for the virus. As a result, contact/droplet precautions were established.

An observation made during the inspection demonstrated that an agency PSW was close to a resident, without their face shield and gloves on. The agency PSW stated they had forgotten it and left the resident without performing hand hygiene, until they were reminded by the inspector. The Clinical Quality Educator (CQE) indicated that all staff are to wear the appropriate personal protective equipment (PPE), including a face shield and gloves.

This observation demonstrated that there was a potential risk to the resident from the agency PSW, as there could be transmission of infectious agents, if IPAC measures are not adhered.

Sources: An observation made with a resident; interviews with an agency PSW, the CQE and other staff. [s. 229. (4)]

2. The licensee failed to ensure that two PSWs, an RPN and an RN participated in the home's IPAC program.

Observations were made through a camera footage. At the time of the footage, the resident was experiencing symptoms and the home was in an outbreak, with contact/droplet precautions established inside all resident rooms. An RN was seen assessing the resident without wearing a gown or face shield. Afterwards, a PSW was seen going into the resident's room without wearing a gown or face shield. Another PSW was seen doffing their gown off while inside the resident's room. Then, an RPN was seen initially inside the resident's room without their gown on. The CQE confirmed that a PSW, an RPN and an RN did not have the appropriate PPE on when they entered the resident's room and that another PSW had doffed off their gown incorrectly.

The observations made in the camera footage demonstrated that these staff were not adhering to the appropriate IPAC measures in place, potentially posing a risk to the resident, who was symptomatic at the time of this footage.

Sources: Camera footage; Interview with the CQE and other staff. [s. 229. (4)]

Issued on this 5th day of May, 2021

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

Original report signed by the inspector.