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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Jun 4, 2021	2021_882760_0017	008524-21	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): June 1, 2021.

The following intakes were completed in this complaints inspection:

A log was related to infection prevention and control.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Clinical Quality Educator (CQE) and the Administrator.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices and observed care activities on the units.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

According to the Critical Incident System (CIS) report submitted to the Director and by the administrator, the home was in an outbreak with a number of residents and staff testing positive for the virus.

Observations were carried throughout the home during this inspection and noted the following:
- An RPN was on a resident home area providing care to a resident without wearing any eye protection. The Clinical Quality Educator (CQE) indicated that all staff are supposed to be wearing eye protection when they are on a resident unit at all times.
- Two PSWs were seen inside a resident's room without wearing a gown. Both PSWs acknowledged that this resident was on contact/droplet precautions, therefore a gown was to be worn if they entered the resident's room.
- A visitor in the home was seen wearing gloves in the hallway of the resident home area. The visitor explained they were told by the home's staff that they could do this. Furthermore, the visitor demonstrated to the inspector the donning of PPE in front of a resident's room and was noted to have performed hand hygiene over their gloves and indicated this was what they were taught during their training by the home. The CQE indicated the visitor was incorrect with their statement about gloves use and donning of PPE. Gloves are not to be worn in common areas of the home, including the hallways of resident home areas and hand hygiene should not be performed on soiled gloves.
- A PSW was seen without eye protection while on a resident home area. The PSW stated that they had forgotten to wear them again after it was cleaned. The PSW understood that eye protection was to be worn at all times while on resident home areas.
- An RPN was seen inside a resident's room with their gown untied at the back. The gown was noted to be loose, while they were providing care to the resident. The CQE stated that as part of the proper process of donning on a gown, they must be tied at the back so that it does not become loose and risk potential contamination.
- A PSW was seen donning two pairs of gloves on their right hand and was going to provide care to a resident. The PSW said this was their practice because if one pair becomes soiled while they are giving care, they can remove it without the layer underneath it becoming soiled. The CQE stated this practice did not follow the home's IPAC program because if the gloves become soiled, they should be completely removed and the staff should perform hand hygiene afterwards. The CQE confirmed that the PSW should not have donned on two pairs of gloves.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a visitor of the home. There was actual risk of harm to residents associated with

these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the CQE, the Administrator, two RPNs, four PSWs, a visitor and other staff; Observations made throughout the home during the inspector's inspection; a CIS Report. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 8th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l’inspection :	2021_882760_0017
Log No. / No de registre :	008524-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 4, 2021
Licensee / Titulaire de permis :	Unionville Home Society 4300 Highway #7, Markham, ON, L3R-1L8
LTC Home / Foyer de SLD :	Union Villa 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Terry Collins

To Unionville Home Society, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Conduct monitoring in all home areas to ensure staff and visitors are adherent to the appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

According to the Critical Incident System (CIS) report submitted to the Director and by the administrator, the home was in an outbreak with a number of residents and staff testing positive for the virus.

Observations were carried throughout the home during this inspection and noted the following:
- An RPN was on a resident home area providing care to a resident without wearing any eye protection. The Clinical Quality Educator (CQE) indicated that all staff are supposed to be wearing eye protection when they are on a resident unit at all times.
- Two PSWs were seen inside a resident's room without wearing a gown. Both PSWs acknowledged that this resident was on contact/droplet precautions, therefore a gown was to be worn if they entered the resident's room.
- A visitor in the home was seen wearing gloves in the hallway of the resident

home area. The visitor explained they were told by the home's staff that they could do this. Furthermore, the visitor demonstrated to the inspector the donning of PPE in front of a resident's room and was noted to have performed hand hygiene over their gloves and indicated this was what they were taught during their training by the home. The CQE indicated the visitor was incorrect with their statement about gloves use and donning of PPE. Gloves are not to be worn in common areas of the home, including the hallways of resident home areas and hand hygiene should not be performed on soiled gloves.
- A PSW was seen without eye protection while on a resident home area. The PSW stated that they had forgotten to wear them again after it was cleaned. The PSW understood that eye protection was to be worn at all times while on resident home areas.
- An RPN was seen inside a resident's room with their gown untied at the back. The gown was noted to be loose, while they were providing care to the resident. The CQE stated that as part of the proper process of donning on a gown, they must be tied at the back so that it does not become loose and risk potential contamination.
- A PSW was seen donning two pairs of gloves on their right hand and was going to provide care to a resident. The PSW said this was their practice because if one pair becomes soiled while they are giving care, they can remove it without the layer underneath it becoming soiled. The CQE stated this practice did not follow the home's IPAC program because if the gloves become soiled, they should be completely removed and the staff should perform hand hygiene afterwards. The CQE confirmed that the PSW should not have donned on two pairs of gloves.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and a visitor of the home. There was actual risk of harm to residents associated with these observations because by not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the CQE, the Administrator, two RPNs, four PSWs, a visitor and other staff; Observations made throughout the home during the inspector's inspection; a CIS Report.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents as there was potential for possible transmission of infectious agents due to the staff and a visitor participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: In the last 36 months, the licensee was found to be non compliant with s. 229 (4) of O. Reg 79/10, and one WN was issued to the home. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 14, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of June, 2021

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office