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
Nov 1, 2021	2021_918426_0004	014933-21	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

FRANK GONG (694426)

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): October 27, 28, 29, 2021.

The following intakes were completed during this Inspection:
Logs/CIS's related to significant changes to a resident's health status

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Clinical Quality Educator and Infection Prevention and Control (IPAC) Lead, Housekeeping staff, and Director of Care (DOC).

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions, and reviewed clinical health records, internal investigation notes, staff schedules, and relevant home policies and procedures.

Inspector #501 was present during this inspection.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 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 staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

The following is further evidence to support the order issued on October 13, 2021, during inspection 2021_718535_0015 to be complied by October 29, 2021.

On a specified date, a visitor was observed in a resident room with specified additional precautions without wearing required Personal Protective Equipment (PPE). RPN #106 and IPAC Lead verified that required PPE should have been worn in rooms with specified additional precautions. RPN #106 and IPAC Lead further indicated that it was the responsibility of the home's staff to ensure that visitors wear appropriate PPE while in rooms with additional precautions.

IPAC Lead verified that failure to ensure staff participated in the implementation of the IPAC program increases the risk of transmitting infectious disease.

Sources: Observation and interviews with RPN #106 and IPAC Lead. [s. 229. (4)]

Issued on this 2nd day of November, 2021

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

Original report signed by the inspector.