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
Apr 20, 2022	2022_882760_0010	012311-21, 013373-21, 016557-21, 016648-21, 017382-21, 017429-21, 001759-22	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

JACK SHI (760), LUCIA KWOK (752)

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): March 24, 25, 28, 2022.

The following intakes were completed in this critical incident inspection:

Seven logs were related to various falls.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), a Physician (MD), Personal Support Workers (PSW), the Clinical Quality Educator (CQE) and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, 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
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff of the home collaborated with the MD to ensure their assessments were integrated related to a resident's change in condition after sustaining a fall.

A review of the progress notes indicated that the resident had sustained a fall. After a few days, the resident had a change in status and requested interventions. The interventions were provided by an on-call physician and requested further diagnostics. The resident's assigned MD assessed the resident a few days after and noted in their documentation that there were no noted concerns with the resident, including no recently experienced falls. The MD reassessed this resident a few weeks after and the resident gave a report about their fall and the change in condition they had experienced. After a couple days later, the resident's substitute decision maker (SDM) brought the resident to the hospital, where they were diagnosed with an injury. The requested diagnostics from the on-call physician was never completed within the home.

The MD of this resident stated they did not receive the proper communication of information from the nurses and therefore, was receiving information directly from the resident themselves about the fall they had sustained. An RPN also added that there were issues around the communication amongst the nurses related to this resident's change in condition that they experienced after their fall.

The Clinical Quality Educator (CQE) confirmed that that there was a lack of communication and collaboration amongst the MD and the registered staff in this situation. The CQE also stated that the lack of collaboration resulted in missed opportunities in providing targeted interventions directed to address the delay in diagnostics along with the change in condition experienced by the resident after their fall.

The following is further evidence to support the order issued on January 12, 2022, during inspection 2021_595110_0016 to be complied by March 31, 2022.

Sources: Review of a resident's progress notes; Interviews with an RPN, the MD, the CQE and other staff. [s. 6. (4) (a)]

Issued on this 20th day of April, 2022

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

Original report signed by the inspector.