Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date August 4, 2022
Inspection Number 2022_1513_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Unionville Home Society

Long-Term Care Home and City
Union Villa, Markham

Lead Inspector
Sami Jarour (570)

Inspector Digital Signature
Sami Jarour
Digitally signed by Sami Jarour
Date: 2022.08.12 09:33:20 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 5-7, 11-15, 2022

The following intake(s) were inspected:
- Intake #014707-21, related to an allegation of abuse of a resident.
- Intake #019233-21, related to an unexpected death of a resident.
- Intake #001246-22, Follow up to Compliance Order (CO) #001 issued on Feb 28, 2022(A1) under Inspection Report #2021_595110_0016 (A1) related to the LTCHA, 2007, s. 6. (4) with a compliance due date of Mar 31, 2022(A1).
- Intake #007868-22, Follow up to Compliance Order (CO) #001 issued on Apr 20, 2022, under Inspection Report #2022_947752_0005 related to O. Reg 79/10, s. 229. (4) with a compliance due date of Jun 10, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6. (4)	2021_595110_0016 (A1)	001	570
O. Reg. 79/10	s. 229. (4)	2022_947752_0005	001	570

The following **Inspection Protocols** were used during this inspection:

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the director was followed as it relates to ensuring all the hand hygiene agents are at least 70-90 percent (%).

Rationale and Summary

On July 9, 2022, there were three expired hand hygiene agents located on one residents home area by three residents' rooms with expiration date of February 2022.

IPAC lead stated that hand hygiene agents beyond expiry dates were not being used at the home and that any expired hand hygiene agents should be removed and replaced.

On July 11, 2022, the IPAC lead indicated that they completed a facility wide audit and that all expired hand sanitizers were removed and replaced.

There was low risk of harm to residents as there were other products used in the home that were not expired.

Date Remedy Implemented: July 11, 2022 [570]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 (d), indicated that the licensee shall ensure proper use of personal protective equipment (PPE), including the appropriate selection, application, removal, and disposal of PPE.

A resident's room was on additional precautions with directions posted on door to wear PPE including eye protection. Staff #110 was not wearing eye protection while inside the resident's room. Staff #110 confirmed that the resident's room had signage of additional precautions and that they forgot to wear the eye protection. The IPAC lead indicated that staff #110 should have had eye protection on when entering a room on additional precautions.

Failure to wear proper PPE could contribute to the spread of infectious agents such as COVID-19 virus.

Sources: Inspector #570's observations, IPAC standards (April 2022), interviews with staff #110 and the IPAC lead. [570]