Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: August 30, 2023

Inspection Number: 2023-1513-0003

Inspection Type:
Critical Incident

Licensee: Unionville Home Society

Long Term Care Home and City: Union Villa, Unionville

Lead Inspector	**Inspector Digital Signature**
Fatemeh Heydarimoghari (742649)	Maria P Pistritto Digitally signed by Maria P Pistritto Date: 2023.09.07 16:00:09 -04'00'

Additional Inspector(s)
Rodolfo Ramon (704757)
Maria Paola Pistritto (741736)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 10, 11, 15, 16, 2023
The inspection occurred offsite on the following date(s): August 14, 2023

The following intake(s) were inspected:

- One Intake related to staff to resident abuse.
- One Intake related to Improper care of resident.
- One Intake related to resident-to-resident abuse.
- One Intake related to an improper transfer.
- Three intakes related to fall with injury.
- Four intakes related to injury of unknown cause.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee shall ensure that the care set out in the plan of care is provided to a resident as specified in the plan.

Rationale and Summary

1) A Critical Incident Report (CIR) was submitted to the Director related to an injury sustained during an improper transfer of a resident. The resident requested a specific mobility device to be trialed. Once received by the home, the Physiotherapist (PT) assessed the mobility device, deemed it unsafe and was not to be used. The PT informed registered staff of the recommendation and documented this in the resident's progress notes. Registered Practical Nurse (RPN) #102 was in charge and communicated to the Personal Support Worker (PSW) staff that the mobility device was not to be used.

PSWs #115 and #116 used the mobility device contrary to the PT's recommendation and direction.

RPN #102 and the Clinical Quality Educator (CQE) confirmed PSW staff were made aware and informed of the PT's safety recommendation for the mobility device.

Failure to implement the plan of care for a resident resulted in injury.

Sources: CIR, resident care plan, investigation notes, progress notes, interview with RPN. [741736]

The licensee has failed to ensure that the care set out in a resident's plan of care related to one to one (1:1) supervision, was implemented.

Rationale and Summary

2) A CIR was submitted to the Director related to an alleged physical abuse in which a resident hit a co-resident. The resident's care plan identified one to one (1:1) care for responsive behaviours.

Inspector #741736 observed the resident after an incident. The inspector approached PSW #108 and asked about the resident's 1:1 care staff. PSW #108 informed the inspector that the 1:1 care staff was on break and that they were providing 1:1 coverage for the resident.

PSW #103, the CQE, and the Behavioural Support Ontario (BSO) Nurse confirmed that the 1:1 role required the PSW to always be with the resident. PSW #108 acknowledged that they were not with the resident at the time of the fall.

Failing to implement the plan of care, specifically with 1:1 care, puts the resident's safety at risk.

Sources: CIR, the resident's care plan, progress notes, BSO documentation, doctor's orders, and medical assessment, interviews with 1:1 support staff, and the CQE. [741736]

WRITTEN NOTIFICATION: CONTINENCE CARE

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

Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that a resident's plan to promote and manage bladder continence was implemented.

A CIR report was submitted due to an allegation of improper care of a resident. The resident did not receive assistance with continence care for a prolonged period of time.

A review of the resident's plan of care indicated they required assistance with continence care during specified times. The home's investigation notes, and the documentation records confirmed that the resident did not receive assistance with continence care as it was specified in the plan of care. The Director of Care (DOC) verified that the resident should have received assistance with continence care.

Failure to implement the plan to promote and manage bladder continence placed the resident at risk of not having their needs met.

Sources: The resident's plan of care, documentation records, the home's investigation notes, and interview with the DOC. [704757]

COMPLIANCE ORDER CO #001 SAFE TRANSFERRING AND TECHNIQUES

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall, at a minimum:

1. Educate PSW# 112, PSW# 115, and PSW# 116 on the proper one-person physical assist technique and the appropriate use of the mechanical lift.
    a) The education will be conducted by a physiotherapist.
    b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.
2. Complete audits on the use and application of one person's physical assist technique and the appropriate use of the mechanical lift once every shift on all shifts, three times a week for a period of 2 weeks.
    a) The audits will be conducted by a member of the management or clinical leadership team.
    b) Keep a documented record of the audits completed, audit completion dates, and any action taken when any issues are identified.

Grounds
The licensee has failed to ensure that staff use safe transferring techniques when assisting a resident.

Rationale and Summary

1) A CIR was submitted to the Director related to an injury sustained during an improper transfer of a resident. Investigation notes confirmed that a resident was being repositioned with a transferring device. The resident sustained an injury that required them to be transferred to a medical facility.

The home's investigation notes confirmed that PSWs #115 and #116 did not perform the transfer according to the resident's plan of care. The home's "15420 Minimal Lifts Program Policy" stated that two persons must always operate the transferring device. At the time of the incident, only one PSW was present to transfer causing the transferring device to tilt and hit the wall. PSWs #115 and #116 were provided training and disciplined.

Failure to use proper transferring techniques caused the resident to sustain an injury.

Sources: Investigation notes, the resident's progress notes, discipline letter, Care Plan, 15420 Minimal Lifts Program Policy, last reviewed November 7, 2018, and interviews with RPN and CQE. [741736]

The licensee failed to ensure that staff used a safe technique when assisting a resident.

Rationale and Summary

2) A CIR report was submitted to the Ministry of Long-Term Care (MLTC), indicating a resident sustained an injury. The resident's care plan indicated the resident required a transferring technique for transferring at the time of the incident.

The home's internal investigation stated that PSW #112 used an improper transfer technique when assisting a resident. The PT indicated that using an improper technique may have caused the resident's injury.

Failure to ensure that staff used a safe technique when transferring the resident could have contributed to their injury.

Sources: The resident's clinical records, home's investigation note, CIR, and interview with PT. [742649]

This order must be complied with by November 24, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the

licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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