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

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Original Public Report

Report Issue Date: July 5, 2024	
Inspection Number: 2024-1513-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Unionville Home Society	
Long Term Care Home and City: Union Villa, Unionville	
Lead Inspector Suzanna McCarthy (000745)	**Inspector Digital Signature**
Additional Inspector(s) Ana Best (741722)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 28-31, 2024 and June 3-7, 2024

The following intake(s) were inspected:

- Two intakes related to falls prevention
- Two intakes related to outbreaks
- An intake related to improper care
- An intake related to a fall resulting in injury
- An intake related an injury with unknown cause
- A complaint related to falls prevention, medication, and housekeeping
- A complainant related to skin and wound care and mobility

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT'S BILL OF RIGHTS

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

The licensee failed to respect the expressed wishes of a resident.

Rationale and Summary

During an initial tour, Inspector #000745 observed a resident attempting to get the Inspector's attention. Upon approaching the resident, the resident informed the Inspector that they had made repeated requests of staff and staff had refused to

respond. The resident expressed distress and requested the assistance of the Inspector.

Following this, the Inspector approached Registered Practical Nurse (RPN) #114 to highlight the resident's request and current level of distress. The RPN responded immediately that there was no staff available to assist the resident and they were not sure when staff would become available. A few moments later, the RPN approached the Inspector and reported that they had spoken with the Falls Lead who informed them that in accordance with the long-term care home's (LTCH) policy the resident's request could not be actioned at that time. The Inspector requested that the policy be produced, and RPN #114 responded that they would provide alternate interventions to the resident. Approximately 30 minutes later the resident was observed to be with staff who were providing the requested support.

During an interview, the Falls Lead was asked to clarify the policy referenced by RPN #114. The Falls Lead reported that they had provided inaccurate direction to the RPN and that there was in fact no policy in place that prohibited the action requested by the resident. The Falls Lead confirmed that the actions of the LTCH in this instance did not support the resident's rights and stated that they would clarify the expectations with staff and ensure that the resident's rights and future requests are respected.

Failure to respond to the resident's request was in direct violation of the Resident's Bill of Rights.

Sources: Observations, record reviews, interviews with the resident, RPN #114 and Falls Lead #117. [000745]

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that falls prevention interventions ordered in the care plan were followed.

Rationale and Summary
On a specified date the Inspector observed the resident in their room with the required interventions absent. A review of records showed that the resident required these interventions as they were a high risk for falls.

Personal Support Worker (PSW) #131 confirmed that the interventions were not in place as ordered and immediately corrected the issue.

Failure to ensure that the ordered falls prevention interventions were in place created an increased risk of the resident experiencing a negative outcome.

Sources: Observations, clinical records, interview with PSW #131. [000745]

WRITTEN NOTIFICATION: ACCOMODATION SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home is maintained in a state of good repair.

Rationale and Summary

During an initial tour of the LTCH, the Inspector noted numerous areas of the home to be in a state of disrepair. The areas of disrepair were identified as follows:

In the first area of the LTCH, the Inspector observed the following:
• water damage to ceiling in the resident dining areas.
• damage to veneer of service counter area in resident dining area with a large portion missing
• missing flooring near entrance to resident garden area
• window lever missing from window immediately beside door to the resident garden area
• a thermostat box cover in a resident common area had sustained significant damage causing it to protrude from the wall with a large gap between the cover and wall with exposed screws and drywall anchors.

In the second home area:
• multiple areas of drywall patched but not repainted
• open/close lever for window located adjacent to the stairwell was missing with a zip tie wrapped around the lever casing.

In the third home area:
• a large portion of the rubber baseboard had been patched in a non-matching colour in the resident spa room and a large section of floor was observed to have been patched with a material that did not match the current flooring in the same spa room.

In the fourth home area:
• multiple areas of flooring in the resident dining room were observed to have strips of black tape covering areas of heavy wear.

During an interview, the Director of Environmental Services and Campus Infrastructure (DEVSCI) confirmed that all areas identified by the Inspector required remediation and reported that they would begin to action the repairs. The DEVSCI additionally reported that the spa room, located in the third home area was currently being assessed for a complete renovation, and as such, the LTCH had applied temporary remediation to the identified areas. The DEVSCI also reported that they had begun the process of procurement for the replacement of the flooring in the fourth home area.

Failure to maintain the home in a state of good repair may create a reduced sense of enjoyment of the home for the residents.

Sources: Observations, interview with the DEVSCI. [000745]

WRITTEN NOTIFICATION: BED RAILS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The licensee has failed to ensure that a resident's bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Rationale and Summary
A CIR (Critical Incident Report) was submitted to the director related to the unknown caused injury to a resident.

A document developed by Health Canada, March 2008, provides the necessary guidance for completing an evaluation of the specified intervention. The Health Canada guide was identified by the Director of the Ministry of Long-Term Care in 2012 and 2019, as the prevailing practice and was shared with the sector.

Upon review of the resident's health records, it was identified they required the use of bed rails as Personal Assistive Service Device (PASD). The care plan directed staff to ensure the bed rail was applied on a specific side of the bed, and to complete safety checks when bed rails were engaged.

The Director of Infection Prevention and Control (IPAC) and the Physiotherapist (PT) confirmed the bed rail was applied to the resident's bed on a specific side, after the reported unknown caused injury.

As per notes documented in Point Click Care (PCC) by the Director of IPAC, during a meeting with Power of Attorney (POA), and PT, a change for a bed was planned for the resident, and the request was placed through the maintenance department.

Review of the audits completed by the LTCH's vendor on a specified date, demonstrated that the serial number and bed system evaluated for the resident the previous year did not match the serial number and bed system that was being used

by the resident at the time of the inspection.

The Director of Care (DOC) confirmed that monthly tracking of bed rails by the registered staff for the year 2024 to date had not been completed monthly as directed by the Resident Safety-Bed Rail policy.

The Maintenance Supervisor and the DOC confirmed the resident have had a bed change, and a bed system assessment had not been completed for the resident.

Failure to complete the necessary assessments in accordance with prevailing practices increased the risk that resident could be harmed.

Sources: Observation, resident health records, The Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, Bed Rail policy, bed audits, and interviews with staff. [741722]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that when a resident demonstrated responsive behaviours actions were taken to respond to their needs, including assessment, reassessment and interventions, and resident's responses to interventions were

documented.

Rationale and Summary

A concern was submitted to the LTCH, notifying the home of the elopement of a resident on a specified date.

Review of the Behaviour Management policy indicated that if strategies to manage behaviours were unsuccessful, a referral was to be made to the Behavioural Supports Ontario (BSO) lead.

Health records for the resident indicated a specified intervention was initiated on a specified date and time. As per the resident's progress notes, the registered staff documented the resident was exhibiting specific behaviours during the same day. Interventions noted in the resident's care plan, directed staff to administered medication as per physician's order, ensured identification (ID), hourly checks, documentation on Point of Care (POC), and to use a specific approach. The resident's medication orders confirmed there was a medication adjustment.

Personal Support Worker (PSW) #125 confirmed knowing that the resident was known to have specific behaviours during an identified time of the day, and frequent checks were completed for the resident. Furthermore, staff confirmed the resident's elopement during their shift.

The BSO Lead indicated they were notified about the resident's elopement days after the incident. On a specific date, they received an email from the nurse indicating the ineffectiveness of the medication change. The BSO nurse confirmed they were not informed the registered staff had initiated a specified intervention on a specified date and a review of the intervention had not been completed.

Failure to ensure proper assessment and management of the resident specified behaviours, may increase the risk of incidents, potentially resulting in harm to the resident.

Sources: LTCH's complaint binder 2024, resident's health records, Behaviour Management policy, and interviews with staff. [741722]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee failed to ensure that common areas, including floors, contact surfaces and wall surfaces were kept in clean condition in a specified home area.

Rationale and Summary
During a tour of the LTCH, in a specified home area it was observed that the dining room floors were sticky. There was observation of built-up grime and dirt around the walls' edges, and a white pillar. There was also noted dry food smeared around the white pillar near the dining room window area. Furthermore, there was observation of spider webs in the corners of the exit doors at the small sitting room area around the staircase.
Upon review of the housekeeping routine documentation and audits' binder for the

housekeeping department, there was no documentation related to the audits completed to the observed areas in the specified home unit.

Interviews with the DEVSCI and the Housekeeping Supervisor confirmed the current condition of the observed common areas was not acceptable as per cleaning routines and best practices of the LTCH.

Failure to ensure common areas in the home, including floors, walls, are kept in clean condition can contribute to health risk, attract pests, and spread of diseases.

Sources: Observations, housekeeping audits, interviews with staff. [741722]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee failed to ensure that cleaning and disinfection procedures were implemented using, at a minimum, a low-level disinfectant for the shower chair in a specified home area.

Rationale and Summary
Inspector 741722 observed the home's practices related to cleaning and disinfection of care equipment, specifically a shower chair in a specified home area.

After assisting a resident with their shower, PSW #107 was observed applying dish washing detergent on the shower chair that was used by the resident.

PSW #107 confirmed they were applying detergent, and acknowledged it was not the appropriate product to use for cleaning and disinfection of the shower chair.

The Director of IPAC confirmed this was not the appropriate product to be used for cleaning and disinfection of shower chairs and indicated a poster with the correct process for the cleaning and disinfection of the shower chair had been posted in the spa room as a reminder to all staff. In addition, the housekeeping supervisor confirmed the required product to be used was Oxyvir Tb one minute contact, available in the home in all home units' spa rooms.

Failure to ensure that proper cleaning and disinfection practices are followed, can lead to spread of infections, and an increased risk to the well-being of residents in the home.

Sources: Observations, best practice protocol for the cleaning and disinfection of shower chairs, interviews with PSW #107, Director of IPAC and Housekeeping Supervisor. [741722]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee failed to ensure the Director was informed when resident went missing and returned shortly after to the home with no injury or adverse change in condition.

Rationale and Summary
A concern was submitted to the LTCH, notifying the home of the elopement of a resident on a specified date.

Health records of the resident indicated they were exhibiting specific behaviours on a specified date.

PSW#125 confirmed the resident was known to exhibit specific behaviours, and specific interventions were to be completed for the resident. Furthermore, staff confirmed the resident's elopement during their shift.

The Director of Care (DOC) indicated the incident was reported to them days after the event.

Failure to ensure prompt reporting and follow up, can lead to loss of trust among residents and families.

Sources: LTCH's complaint binder 2024, resident's health records, and interviews with staff. [741722]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to report an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition within the mandatory timelines.

Rationale and Summary

On a specified date, a resident experienced a fall which required transfer to hospital. This matter was not reported to the Director until a later specified date.

Investigation notes showed that RN #129 conducted an assessment and placed a call to emergency services as a result. The DOC confirmed that the critical incident should have been reported to the Director immediately, but reported that they had no explanation as to why the report was not made.

Failure to report the critical incident to the Director did not have an impact on the resident.

Sources: Record review, interview with DOC. [000745]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

During an inspection related to care concerns involving a resident, the resident's medication orders were reviewed.

Review of the resident's medical orders indicated that on a specific date, the prescribing physician had order to hold on an identified medication, and to discontinue the same medication few days after. Health records confirmed that the medication was administered to the resident on the date specified for discontinuation.

The Director of Care (DOC) confirmed that the resident's medication was administered to the resident, causing no harm to the resident. Additionally, staff indicated a medication error was submitted and investigated.

Failing to ensure that drugs were administered to the resident in accordance with directions for use specified by the prescriber, placed the resident at increased health risk.

Sources: Resident's clinical records, and interviews with staff. [741722]

COMPLIANCE ORDER CO #001 MAINTENANCE SERVICES

NC # Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The DOC or their designate will establish a system by which all falls prevention equipment assigned to a resident is tested by direct care staff once per day to ensure that the equipment is in good working order. The system should at a minimum include the following: the name of staff member responsible for conducting the test, the time, date and outcome of the test as well as what steps were taken for any equipment discovered to be in non-working order. This testing is to be conducted until this order has been complied. The licensee will retain records of this testing and will produced them immediately upon the request of an Inspector.

2.The Falls Program Lead in conjunction with the Physiotherapist will provide in-person training to all direct care staff with regards to what constitutes working and non-working falls prevention equipment and the importance of this equipment being in working order. The Falls Lead shall provide a demonstration of all falls prevention equipment in use in the home to the direct care staff. Records of training dates, attendance and training materials are to be maintained by the licensee and

produced immediately upon the request of an Inspector.

3.The Falls Lead, or their designate, shall conduct random weekly audits of the equipment testing records to ensure that testing of the equipment is being completed as ordered. These audits are to continue on a weekly basis until this order has been complied. Any deficiencies identified are to be recorded and identified staff are to be immediately trained in accordance with the legislated requirements. A written record is to be kept of these audits including any corrective action taken. Records of the audits, corrective actions and any associated retraining provided shall be retained by the licensee and is to be provided immediately upon the request of an Inspector.

4.The DOC or their designate will develop and implement a written procedure that provides staff with clear direction on how to report non-functional falls equipment. This procedure is to include ways in which staff can identify non-working equipment, when to report and to whom. This written procedure is to be produced immediately at the request of an Inspector.

5.The DOC will appoint a staff member to be responsible for the immediate replacement of non-functioning falls equipment. The DOC will ensure that there is a primary and secondary designated contact for each of the three daily shifts as well as a designated secondary contact who is able to provide immediately replacement. The appointed individual is to have access to falls prevention equipment stored in the home and have the authority to replace any equipment identified as not being in working order. The names and contact methods for the identified individuals is to be shared with all direct care staff in the home. The list of appointed staff as well as the notification of process sent to all direct care staff is to be retained and produced immediately upon the request of an Inspector.

Grounds

1. The licensee failed to ensure that a specific falls prevention equipment for a specific resident was in working order.

Rationale and Summary

On a specified date, a resident experienced an unwitnessed fall resulting in injury that required transfer to hospital. Records show that the resident experienced a significant change in health status as a result of the injuries acquired during the fall. According to the resident's care plan, the resident had multiple falls interventions in place at the time of the fall. Investigation notes show that the DOC was informed by PSW #130 and RN #129 that one specified piece of equipment was not in working order at the time of the resident's fall.

The DOC and PSW #130 also confirmed during interviews that the equipment was not working at the time of the resident's fall and reported that the fall was discovered after a PSW in an adjacent room heard a loud noise and went to check on the resident.

Failure to ensure that the specific equipment in the resident's room was in working order created increased risk of delays in staff response time when the resident had fallen.

Sources: Clinical records, interview with DOC #101 and PSW #130. [000745]

2. The licensee failed to ensure that a specified piece of equipment relevant to falls prevention was in working order.

Rationale and Summary

On a specified date Inspector #000745 entered a specified home area and

observed a resident to be lying on the floor. The resident was calling for help repeatedly. At the time of discovery, there was no staff in the area and a specified tool relevant to falls prevention was noted to be non-working. The Inspector went to attempt to locate staff to provide support to the resident and upon return observed IPAC Lead #100 to have arrived in the area and to be providing immediate support to the resident.

A review of the documents revealed that the resident has a known falls history and has numerous falls prevention strategies in place, including the use of a specified piece of falls prevention equipment that was to be tested to be in working order at the beginning of each shift. During an interview with Falls Lead #117, it was confirmed that at the time of the fall, the specified equipment was not functional. When asked whether the equipment had been tested at the beginning of the shift, the Falls Lead said that they were unable to confirm whether the specified equipment had been tested for functionality at the beginning of the shift as the LTCH has no method of tracking functionality and testing.

Failure to ensure that the resident's specified falls prevention equipment was in good working condition created increased risk of the staff not being notified if the resident experienced an unwitnessed fall.

Sources: Resident observations, clinical records, interview with Falls Lead #117. [000745]
This order must be complied with by October 2, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

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

The licensee shall at a minimum

1) Establish a schedule and communication plan for the new Outbreak Management Team (OMT) and Interdisciplinary team to conduct post outbreak debrief sessions to assess IPAC practices and review for effectiveness of the employed approaches in the management of outbreaks. The licensee will retain records of the date and time of the meetings, a list of attendees, the outcome of efficacy assessments and a list of all outbreaks being analyzed. These records are to be produced immediately upon the request of an Inspector.

2) The joint outbreak management team and IPAC team will conduct an analysis of all outbreaks and evaluate the effectiveness of the applied interventions. Should the analysis demonstrate deficiency in the interventions, the joint team will determine and apply corrective actions accordingly. A written record of all meetings, including date, time and attendees, is to be maintained along with meeting minutes which are to include the specific outbreaks being reviewed and any actions taken. These written recommendations are to be produced immediately upon the request of an Inspector.

Grounds

1. The licensee has failed to establish an outbreak management team to work in conjunction with the interdisciplinary Infection Prevention and Control (IPAC) team to review IPAC practices and their efficacy in relation to outbreaks.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director, dated September 2023, section 4.3 states: The licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

Rationale and Summary, Inspector #000745 requested records relevant to the outbreak reviews conducted by the multidisciplinary IPAC team and OMT team and the corresponding recommendations to the licensee with regards to outbreak management practices. The IPAC Lead confirmed that the LTCH did not have an outbreak management team and had not fulfilled their duty as outlined in the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, Additional Requirements 4.3.

Failure to establish an OMT to work in conjunction with the interdisciplinary IPAC team resulted in a reduced opportunity for the analysis of outbreak data and a reduced opportunity to provide the licensee with recommendations for future outbreak management.

Sources: Interview with IPAC Lead. [000745]

2.The licensee has failed to ensure that staff working in a home area under precautions for COVID-19 engaged in proper use of PPE.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director, dated September 2023 section 9.1 states: The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

Rationale and Summary

Inspector #000745 conducted a meal observation in a specified resident dining area. At the time of the observation, the home area was under additional precautions for COVID-19. Signage directing staff and visitors to don a face mask and shield/goggles was observed at the entrance of the home area as well as a PPE caddy containing masks, face shields and alcohol based hand rub (ABHR). According to the IPAC Lead, staff and visitors were to be donning a surgical mask and face shield or goggles for the duration of their time in the home area. During the observation, the Inspector observed Dietary Aide #109 and Dietary Manager #112 to be moving between residents providing support without eye protection in place. Both staff confirmed that they were aware of the PPE requirements in the home and acknowledged that their current PPE was not as per the requirements of the home area.

On the same date, Physician #110 was observed to be seated at the nurse's station of a resident home area with a surgical mask below their chin. Physician #110 confirmed that they were aware of the PPE requirements for the home area and reported that they had been providing care for a COVID-19 positive resident but did not feel that they needed to wear PPE as they were not in direct contact at that specific moment in time.

Failure to don appropriate PPE while in a home area that was under surveillance for COVID-19 created increased risk of transmission of pathogens in the home area.

Sources: Observations, interviews with DA #109, Physician #110 and DM #112. [000745]

This order must be complied with by October 2, 2024

COMPLIANCE ORDER CO #003 CONSTRUCTION, RENOVATION, ETC., OF HOMES

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 356 (3)
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents.

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

1.The home's management team, which shall include the Administrator and the Director of Environmental Services and Campus Infrastructure (DESVCI), will develop and implement a process to ensure that a plan is submitted to the Director related to any alterations, additions, or renovations to the home as per legislative requirements. The process shall include specifications related to:

a. the work to be done.
b. how the work will be carried out.
c. how residents will be affected, including but not limited to safety precautions for residents, staff, visitors, communication to emergency responses services.
d. what steps will be taken to address any adverse effects on residents.
Written records shall be kept and produced to the inspector upon request.

2.The home's management team shall designate a lead who will ensure plans are submitted to the Director in accordance with the home's developed and

implemented process. Written records shall be kept and produced to the inspector upon request.

3.The Administrator and the DEVSCI must be re-educated on the Legislative requirements related to any alterations, additions or renovations to the home, and the Operator's Guide to the Process for Alterations, Renovations or Additions to Existing Long-Term Care Homes guidelines.

4. Keep a documented record of details on who provided the re-education, what the re-education consisted of, the time, date and names of staff who attended. Make this record available to the inspector immediately upon request.

Grounds

The licensee failed to ensure approval from the Director was received prior to commence their brick repair contraction project.

Rationale and Summary

During an inspection it was observed scaffolding around the front facade of the building. The scaffolding was erected around the east side of the building, the west facing facade of the Union Villa's front entrance, and the south sides of the Elson and Joy Miles Care Wing.

Review of the documentation provided by management related to the project, indicated brick repair was required as there had been water damage. The scaffolding had been erected the first week of May 2024. The Ministry of Labour (MOL) project notice was summited on May 15, 2024. Drawings of the site project were submitted to the Town of Markham after project commencement. In addition, documentation confirmed residents, family members and staff were notified once the project had commenced.

Interviews with residents #006 and #007 indicated they had to ensure during the day, to close their window coverings for privacy as workers were observed outside their windows. Furthermore, "smell dust like" on the third floor was also reported by one of the residents.

The Administrator indicated that during the autumn, a repair was completed at the back of the building and at that time, no plan was submitted to the Director. Additionally, the Director of Environmental Services and Campus Infrastructure confirmed no plan was submitted to the Director related to the repairs to the damaged brickwork and rooftop.

Failure to ensure approval was obtained from the Director prior to commence construction, placed the residents' privacy and safety at risk.

Sources: Observations, records related to internal communication with staff and residents, brick repair, resident and family council minutes, interviews with residents, Administrator and DEVSCI. [741722]

This order must be complied with by August 16, 2024

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.