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
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Original Public Report

Report Issue Date: September 12, 2024
Inspection Number: 2024-1513-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Unionville Home Society
Long Term Care Home and City: Union Villa, Unionville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1 to 2, 6, to 9, and 12 to 14, 2024
The following intake(s) were inspected:

- Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

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: FLTCA, 2021, s. 43 (5) (c)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and

The licensee failed to ensure that the documentation required by clauses (a) and (b) was made available to residents and their families, specifically the results and actions taken to improve the long-term care home (LTCH) based on the results of the Resident and Family/Caregiver Experience Survey.

Rationale and Summary

While conducting a Proactive Compliance Inspection (PCI), it was observed that the results and actions taken to improve the LTCH based on the results of the Resident and Family/Caregiver Experience Survey were not posted or made available to the residents and their families in the home. The Continuous Quality Educator confirmed that the results and action plan based on the survey were not posted or available for residents and families in the home. The Continuous Quality Educator stated that this would be posted. The Continuous Quality Educator presented the Inspector with the results and confirmed that the materials would be posted in the designated areas for posting information. Interview with the Administrator confirmed these materials were not posted.

Failing to ensure that the documentation of the results and action plan of the Residents' and Family Experience Survey were available to all residents and families posed no risks to the residents of the home.

Sources: Observations, and interviews with the Continuous Quality Educator and the Administrator.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the Visitors policy was posted in the LTCH.

Rationale and Summary

While conducting a tour of the home, the Inspector observed that the Visitors policy was not posted in the home. During an interview with the Director of Infection Prevention and Control and Inspection Protocols, it was confirmed that the policy was not on the posting boards in the entrance or anywhere else in the home.

By not ensuring that policy is posted staff, visitors and residents may not be aware of the policy.

Sources: Observations, Interview with the Director of Infection Prevention and Control and Inspection Protocols.

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY: ADVICE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43 (4)

Resident and Family/Caregiver Experience Survey

s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee failed to seek the advice of the Family Council, if any, in acting on the results of the Resident and Family/Caregiver Experience Survey.

Rationale and Summary

During a Proactive Compliance Inspection (PCI), a review of the Family Council Meeting minutes indicated that the results of the Resident and Family/Caregiver Experience Survey were not shared with the Family Council as well as the home's action plan for improvement based on the results. Additional record review of the Residents' Council Meeting minutes showed that the results of the survey were available. The Family Council President (former), Continuous Quality Educator and Administrator confirmed that the results and action plan were not provided to the Family Council and the Family Council was not provided the opportunity to advise the home and make suggestions to the home on acting on the results of the survey.

Failing to ensure advice was sought from the Family Council in acting on the results of the Resident and Family/Caregiver Experience Survey, provided a missed opportunity for the home to meet resident and family expectations.

Sources: Family Council Meeting minutes and interviews with the Family Council President, the Continuous Quality Educator and the Administration.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that resident's symptoms indicating the presence of infection were recorded on every shift.

Rationale and Summary

The inspector reviewed the, 'monthly statistics and surveillance form' of the home which identified residents with infections. The resident was noted to have an infection. was prescribed treatment for the illness. According to the resident's progress notes, their infectious symptoms were not recorded on the night shift for the entire duration of the resident's treatment.

The Director of Care (DOC) and the Director for IPAC and IP confirmed that the resident's symptoms should have been recorded on every shift during this time period.

Failing to record resident's infectious symptoms every shift may hinder staff from monitoring the resident and their response to the treatment.

Sources: Resident's clinical records and interviews with the DOC and Director for IPAC and IP.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of but not limited to every designated lead of the home.

Rationale and Summary

A review of the home's Quality Committee Meeting minutes. It indicated that every designated lead of the home was not in attendance at the meeting and no regrets for lack of attendance were noted. Additionally, review of the membership list of the Quality Committee Team members provided by the home's Continuous Quality Educator further indicated that not every designated lead of the home was a member of the home's Quality Committee. Interviews with both the Continuous Quality Educator and the Administrator confirmed that not every designated lead of the home was a member of the Quality Committee team.

Failing to ensure that every designated lead of the home was a member of the Quality Committee provided a missed opportunity by the home to seek advice and input from various programs in the home.

Sources: Membership list of the home's Quality Team members, Quality Committee Meeting minutes, and interviews with the Continuous Quality Educator and the Administrator.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of but not limited to the home's pharmacy service provider.

Rationale and Summary

A review of the home's Quality Committee Meeting minutes. It indicated that the home's pharmacy service provider was not in attendance at the meeting and no regrets for lack of attendance were noted. Additionally, review of the membership list of the Quality Committee Team members provided by the home's Continuous Quality Educator further indicated that the home's pharmacy service provider was not a member of the Quality Committee. Interviews with both the Continuous Quality Educator and the Administrator confirmed that the home's pharmacy service provider was not a member of the Quality Committee team.

Failing to ensure that the home's pharmacy service provider was a member of the Quality Committee provided a missed opportunity by the home to seek advice and input from a pharmacological viewpoint.

Sources: Membership list of the home's Quality Team members, Quality Committee Meeting minutes, and interviews with the Continuous Quality Educator and the Administrator.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY

IMPROVEMENT COMMITTEE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of but not limited to at least one employee of the home who is a member of the regular nursing staff of the home.

Rationale and Summary

A review of the home's Quality Committee Meeting minutes. It indicated that at least one employee of the home who is a member of the regular nursing staff of the home was not in attendance at the meeting and no regrets for lack of attendance were noted. Additionally, review of the membership list of the Quality Committee Team members provided by the home's Continuous Quality Educator further indicated that at least one employee of the home who is a member of the regular nursing staff of the home was not a member of the Quality Committee. Interviews with both the Continuous Quality Educator and the Administrator confirmed that at least one employee of the home who is a member of the regular nursing staff was not a member of the Quality Committee team.

Failing to ensure that at least one employee of the home who is a member of the regular nursing staff of the home was a member of the Quality Committee provided a missed opportunity by the home to seek advice and input from a frontline and operational viewpoint.

Sources: Membership list of the home's Quality Team members, Quality Committee Meeting minutes, and interviews with the Continuous Quality Educator and the Administrator.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of but not limited to at least one employee of the home who is a Personal Support Worker (PSW) of the home.

Rationale and Summary

A review of the home's Quality Committee Meeting minutes. It indicated that at least one employee of the home who is a PSW of the home was not in attendance at the meeting and no regrets for lack of attendance were noted. Additionally, review of the membership list of the Quality Committee Team members provided by the home's Continuous Quality Educator further indicated that at least one employee of the home who is a PSW of the home was not a member of the Quality Committee. Interviews with both the Continuous Quality Educator and the Administrator confirmed that at least one employee of the home who is a PSW was not a member of the Quality Committee team.

Failing to ensure that at least one employee of the home who is a PSW of the home was a member of the Quality Committee provided a missed opportunity by the home to seek advice and input from a direct care and operational viewpoint.

Sources: Membership list of the home's Quality Team members, Quality Committee Meeting minutes., and interviews with the Continuous Quality Educator and the Administrator.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of but not limited to one member of the home's Residents' Council.

Rationale and Summary

A review of the home's Quality Committee Meeting minutes. It indicated that at least one member of the home's Residents' Council was not in attendance at the meeting and no regrets for lack of attendance were noted. Additionally, review of the membership list of the Quality Committee Team members provided by the home's Continuous Quality Educator further indicated that at least one member of the home's Residents' Council of the home was not a member of the Quality Committee. Interviews with both the Continuous Quality Educator and the Administrator

confirmed that one member of the home's Residents' Council was not a member of the Quality Committee team.

Failing to ensure that one member of the home's Residents' Council was a member of the Quality Committee provided a missed opportunity for the home to seek advice from residents to meet resident's expectations in the home.

Sources: Membership list of the home's Quality Team members, Quality Committee Meeting minutes, and interviews with the Continuous Quality Educator and the Administrator.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of but not limited to one member of the home's Family Council.

Rationale and Summary

A review of the home's Quality Committee Meeting minutes. It indicated that at least one member of the home's Family Council was not in attendance at the meeting and no regrets for lack of attendance were noted. Additionally, review of the membership list of the Quality Committee Team members provided by the home's Continuous Quality Educator further indicated that at least one member of the

home's Family Council was not a member of the home's Quality Committee. Interviews with both the Continuous Quality Educator and the Administrator confirmed that one member of the home's Family Council was not a member of Quality Committee team.

Failing to ensure that one member of the home's Family Council was a member of the Quality Committee provided a missed opportunity for the home to seek advice from a family member to meet families' expectations in the home.

Sources: Membership list of the home's Quality Team members, Quality Committee Meeting minutes, and interviews with the Continuous Quality Educator and the Administrator.

COMPLIANCE ORDER CO #001 COOLING REQUIREMENTS

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23 (4) (a)
Cooling requirements
s. 23 (4) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and

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

1. All registered nursing staff (inclusive of agency staff), maintenance staff and all management of the long-term care home will be provided in-person training related to the licensee's 'Preventing Heat-Related Illness Program'. The licensee will ensure that all required staff and managers are aware of their role and responsibility in keeping residents comfortable and safe. The Executive Director will be responsible

to ensure this re-training has been completed. A documented record is to be kept of education provided, including staff signatures and accurate staff schedule detailing who worked on each unit, each day, and each shift.

2. Communication will be provided to all nursing and support staff as to their role and responsibility in keeping residents safe and comfortable during hot weather, including strategies to keep hot air temperatures to a minimum inside the home and keep residents hydrated. Any communication regarding 'Preventing Heat-Related Illness Program' is to be retained, including dates which was communicated to staff. Documentation of the communication is to be kept for the Inspectors review.

Grounds

The licensee failed to ensure that the heat related illness prevention and management plan for the home was implemented for the entire home on a day between May 15 to September 15, on which the outside temperature was forecasted at 26 degrees Celsius or above at any point during the day.

Rationale and Summary

During the initial tour of the LTCH, windows in the home's hallway in three separate home areas were observed to be opened. A heat warning advisory was in effect at the time of observation. Inspectors noted the warm temperature in the area as a result of the open windows. No residents were seen in the area at the time of the observation.

The licensee's policy titled, Heat-Related Illness prevention and management directed staff to be prepared to monitor and respond to individual resident needs during hot weather, including taking measures to prevent heat-related illness. The policy indicated that during periods of hot weather, windows and blinds should be closed to help keep surroundings cooler. These measures can be implemented to ease resident discomfort.

The inspector informed the maintenance supervisor about the concern regarding the three open windows during the heat advisory, which resulted in the warm temperature of the area.

The maintenance supervisor indicated that the temperature was 29.3 degrees Celsius when they pointed the infrared thermometer handheld device towards the wall. They confirmed that the windows should have been closed and covered with blinds during the heat alert warning.

Both the Director of Care (DOC) and Maintenance supervisor confirmed that the interventions required on heat advisory days included closing all the windows and blinds to help surroundings cooler.

Failing to ensure that the heat related illness prevention and management plan was implemented for the home put the resident at risk for complications related to heat related illnesses.

Sources: Weather report, in Unionville, Ontario, the home's "LTC - Heat Related Illness" policy, interviews with DOC and Maintenance Supervisor.

This order must be complied with by November 7, 2024

COMPLIANCE ORDER CO #002 AIR TEMPERATURE

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

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

1. The ESM will develop and implement a process to ensure that air temperature is taken at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in the following areas:

a. At least two resident bedrooms in different parts of the home.

b. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

c. Every designated cooling area,

2. This process will be communicated to all staff identified as being responsible to complete the temperatures. A record of how this is communicated is to be retained and provided to the inspector immediately upon request.

3. The ESM or a designate will conduct a daily audit for 2 weeks and then weekly audit for 4 weeks to ensure that all required temperatures are taken, recorded and corrective action is documented when the temperature is outside of the acceptable range. A documented record of the audits will be maintained and provided to the inspector immediately upon request.

Grounds

The licensee failed to ensure that the air temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 246/22, s. 24 (3).

Rationale and Summary

During document review, the home provided two types of temperature audits: manual and electronic. The audits did not match each other, as there was significant missing documentation noted in the manual documentation. The home's Electronic

Air Temperature Monitoring Log was also missing documentation for a certain period of time.

The Director of Environmental services confirmed that the home was expected to record the air temperature three times a day and document it electronically.

The Maintenance Supervisor acknowledged that no one was assigned to take the evening air temperature, and they used the calculated average temperature to fill in the data on the electronic form. The maintenance supervisor also confirmed that they used the average air temperature to fill in the gaps where air temperature documentations was missing.

Failure to ensure the required temperatures were documented increased the risk of possible high temperatures not being identified, impacting the home's ability to implement their heat related illness prevention and management plan (HRIPMP) as required.

Sources: Air Temperature Log, Hot Weather-Related Plan, Interviews with maintenance supervisor and the Director for Environmental services.

This order must be complied with by November 7, 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.