



**Ministry of Health and  
Long-Term Care**  
**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division**  
**Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé**  
**Direction de l'amélioration de la  
performance et de la conformité**

Toronto Service Area Office  
5700 Yonge Street, 5th Floor  
TORONTO, ON, M2M-4K5  
Telephone: (416) 325-9660

Facsimile: (416) 327-4486

Bureau régional de services de  
Toronto  
5700, rue Yonge, 5e étage  
TORONTO, ON, M2M-4K5  
Téléphone: (416) 325-9660

Télécopieur: (416) 327-4486

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 2, 2013	2013_102116_0028	T-293-13	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**

**SARAN DANIEL-DODD (116)**

**Inspection Summary/Résumé de l'inspection**



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

---

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 27, 28, 2013**

**T-293-13**

**During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care of Operations, Director of Care and staff members of the home.**

**During the course of the inspection, the inspector(s) reviewed the health record of Resident #1 and education in-service documentation on falls prevention and safe transferring techniques.**

**The following Inspection Protocols were used during this inspection:  
Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

---

**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

**Legendé**

WN – Avis écrit

VPC – Plan de redressement volontaire

DR – Aiguillage au directeur

CO – Ordre de conformité

WAO – Ordres : travaux et activités



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff use safe transferring techniques when assisting Resident #1.
  - The plan of care for Resident #1 documents the resident requires all transfers to be conducted by two person(s) and a mechanical lift.
  - On a specified date, a front line staff member transferred Resident #1 by means of a mechanical lift without the assistance of another staff member. Resident #1 sustained an injury as a result of being transferred contrary to the plan of care [s. 36.].

**Additional Required Actions:**

**VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring techniques when assisting Resident #1, to be implemented voluntarily.**



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

---

**Issued on this 9th day of July, 2013**

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