



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

**Rapport d'inspection  
prévus le *Loi de 2007  
les foyers de soins de  
longue durée***

**Ministry of Health and Long-Term Care**  
Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

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

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<b>Date(s) of inspection/Date de l'inspection</b> August 31, 2010	<b>Inspection No/ d'inspection</b> 2010_132_8574_31Aug112837	<b>Type of Inspection/Genre d'inspection</b> Complaint T0895 -2010
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**Licensee/Titulaire**  
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, Markham, ON, L3R 1L8

**Name of Inspector(s)/Nom de l'inspecteur(s)**  
Rosemary Lam, #132

**Inspection Summary/Sommaire d'inspection**

The purpose of this inspection was to conduct a complaint inspection. T0895 -2010

During the course of the inspection, the inspector spoke with:  
Administrator  
Physician  
Director of Care.  
Registered Nursing staff from the care unit  
PSW staff from care unit  
Residents from care unit

During the course of the inspection, the inspector reviewed medical file for the involved resident and three (3) other residents.

The following Inspection Protocols were used in part or in whole during this inspection:  
Nutrition and Hydration  
Skin and Wound Care

Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN  
2 VPC  
0 CO

**NON-COMPLIANCE / (Non-respectés)**

**Definitions/Définitions**

WN – Written Notifications/Avis écrit  
VPC – Voluntary Plan of Correction/Plan de redressement volontaire  
DR – Director Referral/Régisseur envoyé  
CO – Compliance Order/Ordres de conformité  
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

**WN #1: THE LICENSEE HAS FAILED TO COMPLY WITH THE Long-Term Care Homes Program Manual Standards and Criteria B2.4 : Each resident's plan of care shall reflect his/her current strengths, abilities, preferences, needs, goals, safety/security risks, and decisions including advance directives provided by the resident or any substitute decisions provided by the lawfully authorized person . The plan of care shall give clear directions to staff providing care.**

**Findings:**

1. The plan of care for a resident did not provide clear directions to staff providing care. A reported verbal discussion that occurred between the Power of Attorney and the physician regarding a change in the plan of care was not documented in the resident's health record.

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WN#2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 6 (11) b.

When a resident is reassessed and the plan of care reviewed and revised:

b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

**Findings:**

1. Different approaches were not considered in the revision of the plan of care for a resident when care regarding wound management set out in the plan of care was not effective.
2. Different approaches were not considered in the revision of the plan of care for a resident when care regarding pain management set out in the plan of care was not effective.

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WN#3: The Licensee has failed to comply with: LTCHA 2007, S.O. 2007, c. 8, s. 6 (5). The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.



Findings:

1. A resident's substitute decision maker was not given the opportunity to participate fully in the development of the plan of care. The home staff documented that family had voiced concern however, they did not communicate these concerns to the on call physician.

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WN#4: The Licensee has failed to comply with: LTCHA 2007, S.O. 2007, c. 8, 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

Findings:

1. A resident had an open wound area. There was a signature for one treatment only refused by the resident. There were no other signatures for wound treatments as required on the remaining days. No other attempts to change the dressing occurred or documented in medical file.
2. A resident's wound dressing was not changed 3 times a week as per the home's wound protocol and as written on the TAR. The wound dressing was done only 2 times a week. The wound was infected requiring Antibiotic treatment. Nutritional supplement was not provided as recommended by the dietitian to aid with wound healing. The dietitian's recommendation was not signed by the physician and therefore was not processed by staff.
3. A resident's TAR only indicated treatment as per wound protocol, however the specific details of that protocol was not available and was not signed for.

**VPC – Pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 152 (2) the licensee is hereby requested to prepare a written plan of correction for ensuring staff provides care as set up in the plan of care. This is to be implemented voluntarily.**

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WN#5: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 6 (8). The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Findings:

Registered Dietitian's recommendation written on the Dr's order was not signed by the physician. The recommendation for nutritional supplements was not transcribed onto the Medication Administration sheet. Staff (Charge nurses, Personal Support Worker, Dietary staff) was not aware of this need.

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WN# 6: The Licensee has failed to comply with O. Reg. 79/10, s. 231 Every licensee of a long-term care home shall ensure that, (b) the resident's written record is kept up to date at all times. .

Findings:

1. A resident did not have weekly wound assessment signed off on TAR

**VPC – Pursuant to LTCHA, 2007, S.O. 2007, c. 8, s. 152 (2) the licensee is hereby requested to prepare a written plan of correction for ensuring staff conducts and documents weekly wound assessment and care outcomes in resident's health record. This is to be implemented voluntarily.**



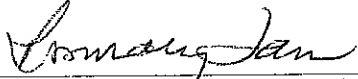
Inspector ID #: 132

WN# 7: The Licensee has failed to comply with: LTCHA 2007, S.O 2007, c. 8, s. 6 (1). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. Verbal instruction regarding specific turning instruction for a resident was not documented in the plan of care.

Inspector ID #: 132

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: _____ Date: _____	 Date of Report: (if different from date(s) of inspection). Sept 21, 2010