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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2022	2021_595110_0016 (A1)	015494-21, 015495-21, 018312-21	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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been amended to reflect the Licensee's request for an extension to the Compliance Due Date.

Issued on this 28th day of February, 2022 (A1)

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

Original report signed by the inspector.

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

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Union Villa
4300 Highway #7 Unionville ON L3R 1L8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 17, 21 to 24, 2021.

The following intakes were inspected during this Critical Incident (CI) inspection:

Log #015494-21 a follow-up to Order #002 issued during inspection #2021_718535_0015 related to duty to protect resident from abuse and neglect.

Log #015495-21 a follow-up to Order #001 issued during inspection # 2021_718535_0015 related to infection prevention and control practices during meal services

Log #018312-21 related to an unexpected death of a resident.

Infection Prevention and Control Inspection was also completed.

During the course of this Inspection, the Inspectors toured resident home areas, observed infection control practices, staff to resident interactions, resident to resident interactions, and dining and snack services. Reviewed electronic clinical health records, relevant nursing staff training contents and records, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Administrator, Infection Prevention and Control Lead, Nursing Managers (Registered Nurses), Registered Practical Nurses, Registered Dietitian, Personal Support Workers, Environmental Services Manager, Housekeepers, COVID-19 Screeners, Residents, and Long-Term Care Visitors.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2021_718535_0015	722469
O.Reg 79/10 s. 229. (4)	CO #001	2021_718535_0015	529

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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so

that their assessments are integrated, consistent with and complement each other.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care that revealed the unexpected death of resident #001 related to diagnosis A and natural causes.

A record review revealed resident #001 had been hospitalized, and returned to the home with several diagnoses including diagnosis A.

The resident’s written plan of care was updated to include interventions relevant to diagnosis A. Interventions included directing the registered staff to monitor the resident for specific signs and refer for further assessment as required. Staff were also instructed to position the resident in a specific manner for a specific time period.

Documentation started upon the residents return from hospital, by the evenings RPN, #120, that the resident presented with a clinical symptom and a plan to continue to monitor. A day later, evidence of the resident's symptom was again documented by the evenings RPN #120 and a plan to follow up with the physician that week. The following next two days documentation by the evening RPN #120 revealed that resident #001 continued with this symptom. The next day RPN #120 documented the resident's symptom was more than usual and to continue to monitor. Six days after the resident returned from the hospital RPN #120 during a day shift documented the resident again was presenting with this clinical symptom.

Interviews with PSWs working the six days revealed nothing had been reported during shift report related to resident #001 but staff had awareness of the resident's clinical symptom. Day RPN #112 also shared that nothing had been reported related to monitoring the resident; was aware of the resident's symptom and stated they should have documented this awareness and the change in the resident's condition.

A review of 24 hour shift reports, progress notes and doctor's communication book failed to identify any collaboration with or assessment by the physician.

An interview with the registered dietitian (RD) revealed no knowledge of receiving a referral for the resident's clinical symptom and confirmed that with a prior history

of diagnosis A, staff should have collaborated with them as further interventions could have been considered. A record review failed to reveal a referral to the RD.

On the evening shift of the six day, the resident was assessed and pronounced dead. The cause of death was identified to include diagnosis A.

Interviews with PSW #121, #125 and #122 shared an unawareness that the resident's plan of care required staff to position the resident in a specific manner for a specific time period.

The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001's clinical symptom so that their assessments are integrated, consistent with and complement each other.

Sources: Residents health record paper and electronic, 24 hour shift reports, doctors communication book, staff interviews with PSWs, dietary aide, registered dietitian, registered practical nurses and nurse manager. [s. 6. (4) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that hand hygiene was provided to the residents prior to nourishment time as indicated in the home's Resident Hand Hygiene policy (revised November 2021) was complied with.

The Long Term Care Act, s. 86 (1) requires that the licensee to have an infection prevention and control program.

Ontario Regulation 79/10, s. 229 (4) requires staff participation and implementation in the infection prevention and control program.

The home's Resident Hand Hygiene policy indicates that residents should complete hand hygiene prior to nourishment. PSW #130 was noted providing nourishment to residents without offering or ensuring hand hygiene was completed. On December 22, 2021 PSW #130 advised inspector that hand hygiene was not required before nourishment as hand hygiene was provided to resident after breakfast. Inspector spoke with IPAC Lead (RN #117) on December 23, 2021, who confirmed that hand hygiene was required before nourishment.

Sources: Observations, Resident Hand Hygiene policy (revised November 2021), interview with PSW #130, interview with IPAC lead #117. [s. 8. (1)]

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 the the homes' Resident Hand Hygiene policy is complied with, to be implemented voluntarily.

Issued on this 28th day of February, 2022 (A1)

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

Original report signed by the inspector.

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DIANE BROWN (110) - (A1)
Inspection No. / No de l'inspection :	2021_595110_0016 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015494-21, 015495-21, 018312-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 28, 2022(A1)
Licensee / Titulaire de permis :	Unionville Home Society 4300 Highway #7, Markham, ON, L3R-1L8
LTC Home / Foyer de SLD :	Union Villa 4300 Highway #7, Unionville, ON, L3R-1L8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Terry Collins

To Unionville Home Society, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee must be compliant with s. 6 (4) of the Long-Term Care Homes Act, S.O. 2007, c. 8.

Specifically, the licensee must ensure:

1. Registered staff are provided with re education on the role of collaborating with each other and others involved in the different aspects of care including PSWs, physician and registered dietitian to ensure that changes in a resident's health status are assessed in a collaborative manner.

2. Re education shall include a focus on the importance of documentation of changes in a resident's health status to facilitate collaboration between shifts.

Grounds / Motifs :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

A critical incident system (CIS) report was submitted to the Ministry of Long-Term Care that revealed the unexpected death of resident #001 related to aspiration and

natural causes.

A record review revealed resident #001 had been hospitalized October 2021, and returned to the home November 7, 2021 with a several diagnoses including aspiration pneumonia.

The resident's written plan of care was updated November 8, 2021, to include a downgraded diet texture, thickened fluids and a risk of choking related to aspiration pneumonia, seizure and stroke. Interventions included directing the registered staff to monitor resident #001's decreased ability to eat and swallow and refer to the registered dietitian or speech language pathologist for further assessment as required; to position the resident at an approximate 90 degree angle and keep the resident up for 30 minutes after meals.

Documentation started November 8, 2021, by the evenings RPN, #120, that the resident was coughing occasionally after meals with the plan of continuing to monitor. On November 9, 2021, evidence of the resident coughing occasionally after meals, was documented by the evenings RPN #120 and that the resident was bringing up clear phlegm and to follow up with the physician that week. November 10 and 11, 2021, documentation of the resident coughing continued by the evening RPN #120. On November 12, 2021 RPN #120 documented the resident ate and drank well but around1800hrs they started to cough more than usual and to continue to monitor. November 13, 2021 RPN #120 during a day shift documented the resident was coughing after each meal, in bed most of the time and was very weak.

Interviews with PSWs working between November 8 and 13, 2021 shared that nothing had been reported during shift report related to resident #001 but staff had awareness of the resident's cough, describing it as if the resident was trying to clear their throat. Day RPN #112 also shared that nothing had been reported related to monitoring the resident and their coughing, but was aware of the resident's cough and stated they should have documented this awareness and the change in the resident's condition.

A review of 24 hour shift reports, progress notes and doctors communication book failed to identify any collaboration with or assessment by the physician.

An interview with the registered dietitian (RD) revealed no knowledge of receiving a

referral for the resident's coughing and confirmed that with a prior diagnosis of aspiration pneumonia, staff should have collaborated with them as further interventions could have been considered. A record review failed to reveal a referral to the RD.

On the evening shift of November 13, 2021, the resident went to the dining room for dinner, was returned to their room, toileted and placed into bed by PSW #121. Then shortly afterwards the resident rang the call bell and was toileted by PSW #125. PSW #125 stated they waited about five minutes outside the washroom waiting for the resident to finish at which point they checked on the resident and found them with aspirated food coming from their nose and mouth and slumped over. The resident was assessed and pronounced dead. The cause of death was identified as aspiration pneumonia.

Interviews with PSW #121, #125 and #122 shared an unawareness that the resident's plan of care required staff to keep the resident up for 30 minutes after meals.

The licensee failed to ensure staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001's coughing so that their assessments are integrated, consistent with and complement each other.

Sources: Residents health record paper and electronic, 24 hour shift reports, doctors communication book, staff interviews with PSWs, dietary aide, registered dietitian, registered practical nurses and nurse manager.

An order was made by taking the following factors into account:

Severity: There was actual harm to the resident since they passed away from aspiration pneumonia.

Scope: The scope of this non-compliance was isolated since only one resident was affected.

Compliance History: The licensee had had previous non compliance but to a different sub section.
(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2022(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, commercial courier or by fax 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
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of February, 2022 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by DIANE BROWN (110) - (A1)

Service Area Office / Bureau régional de services : Central East Service Area Office