Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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Public Copy/Copie 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
Apr 20, 2022	2022_947752_0005	018935-21, 018957-21, 019278-21	Complaint

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

LUCIA KWOK (752)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 22, 23, 24, 25, 28, and 29, 2022.

**Two logs related to an alleged staff to resident abuse;
a log related to care concerns.**

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Clinical Quality Educator, Registered Nurses (RN), Infection Prevention and Control (IPAC) lead, Registered Practical Nurses (RPN), Physiotherapist (PT), Social Services Worker (SSW), former Behavioural Support Ontario (BSO) Nurse, housekeeper, laundry aide, and Personal Support Worker (PSW).
The inspector conducted a tour of the home, observed the provision of care, and resident and staff interactions. The inspector reviewed pertinent clinical records, and relevant policies and procedures, LTCH's investigation notes, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically, related to hand hygiene

(HH) practices for residents, universal masking, availability of Personal Protective Equipment (PPE), and donning and doffing the appropriate PPE in additional precaution rooms.

Observations were conducted throughout the inspection and the following were noted:

- A resident room had droplet/contact precaution signage. The PPE caddie outside the room was missing gloves. A visitor in the room did not don face shield and gloves and was delivering lunch tray to the resident.
- A resident room had contact precaution signage. The PPE caddie was missing gowns, and sanitizing wipes.
- Two resident rooms had contact precaution signage. The PPE caddies outside the rooms were missing gloves.
- A resident room had contact precaution signage. After making direct contact with the resident, one staff exited the room and did not change their soiled mask. The staff stated that as there were no active COVID-19 cases so there was no need to change their mask.
- An alcohol-based hand rub (ABHR) bottle outside of a resident room was missing the dispensing pump.
- A contractor was inside a resident room and wore a surgical mask on their chin.
- On several occasions during nourishment pass, staff did not provide HH assistance to residents in their rooms at point of service. Personal Support Worker (PSW) #106 stated that residents received HH before being transported to their room.

Registered Practical Nurse (RPN) #105 stated all staff were responsible to remind visitors and contractors of adherence to the home’s IPAC protocols and ensure that PPE caddies were stocked with the required supplies. RPN #107 demonstrated that there was extra PPE supplies in the nursing stations and medication rooms.

The home’s IPAC lead and Clinical Quality Educator stated that the expectation was for staff to provide residents with HH at point of service.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations conducted on March 22, and 23, 2022; Interviews with RPN #105, #107, PSW #105; IPAC lead, Clinical Quality Educator and other staff; home’s

IPAC policies and procedures. [s. 229. (4)]

Additional Required Actions:

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

WN #2: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's care set out in their plan of care was based on the resident’s needs and preferences.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to care concerns.

RPN #110 and Registered Nurse (RN) #112 shared that the social services team would review a resident's admission paperwork and compile the information into a admission cheat sheet for staff to familiarize themselves with the resident's needs and preferences. This cheat sheet was considered a part of the plan of care.

A resident's admission information cheat sheet documented their preference for an activity of daily living. The resident's preference was documented in their initial nursing assessment but it was not indicated in their care plan.

RN #112 shared that the home's process was for the Behavioural Support Ontario (BSO) Nurse to collaborate with the family to complete a PIECES of personhood document with information about a resident's preferences, and history. The resident's PIECES Of personhood document identified the reason for the resident's preference. The former BSO nurse stated that resident's caregiver had relayed their preference and it should be implemented in the care plan.

Based on the resident's documentation survey report and progress notes, they did not receive their preference for the activity of daily living. RPN #110 stated that staff were aware of the resident's preference and should have followed it when providing care.

The DOC acknowledged that the resident should have been provided with their preference for the activity of daily living.

The resident was negatively impacted as a result of their preference not being respected and promoted by the care team.

Sources: Resident's progress notes, clinical assessments, admission records, Point of Care documentation, care plan; Interviews with RPN #110, RN #112, former BSO nurse, DOC. [s. 6. (2)]

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 ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids. O. Reg. 79/10, s. 37 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that a resident received assistance to use their personal aid.

The resident's care plan documented that to ensure their personal aid was cleaned and being used by the resident at all times while awake for safety. The care plan further indicated to store the resident's personal aid at the nursing station at night or when not in use for safe keeping.

During an observation, the resident was in the resident home area (RHA) without their personal aid. RPN #110 demonstrated that the resident's labeled personal aid was stored in the medication cart. The RPN stated that the unit's practice was to store residents' personal aides in the medication cart. They stated that registered staff were responsible to provide residents with their personal aids in the beginning of the day and collect them prior to bed time.

The Director of Care (DOC) stated that residents' personal aids should not have been kept in the medication cart as they were not medication.

By not providing assistance to the resident with their personal aid, their safety and well being were potentially compromised.

Sources: Observation on March 25, 2022; Interviews with RPN #110 and DOC. [s. 37. (2)]

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 each resident receives assistance, if required, to use personal aids, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident’s area of altered skin integrity was assessed weekly by a registered staff member.

A complaint was lodged to the MLTC related to an alleged staff to resident abuse. The complainant discovered two areas of altered skin integrity on the resident.

An initial skin assessment was completed and documented one of the area of altered skin and its measurements. There was a two week gap of weekly skin assessments for this area altered skin integrity.

An initial skin assessment was completed and documented the other area of altered skin and its measurements. A subsequent skin assessment was conducted the following week, but the measurements of the area was not documented.

RN #116, the home’s wound care lead, shared that altered skin integrity included bruises, rash, disorder of the skin, pressure ulcers, any abrasion and skin tear. The RN stated that registered staff were to conduct an initial skin assessment and subsequent weekly skin assessments until the area has resolved. The expectation was for registered staff to document the pertinent clinical information on the area including, measurements, exudate, peri wound, status, and treatment.

There was potential risk for the resident as they might not have received timely treatment and monitoring for the areas of altered skin integrity.

Sources: Resident’s progress notes, skin assessments, electronic treatment administration record, home’s skin and wound care policies and procedures; Interviews with RN #116, DOC and staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to submit a written complaint concerning the care of a resident immediately to the Director.

A complaint was lodged to the MLTC related to care concerns of a resident.

The complainant had sent a written complaint email to the Social Service Worker (SSW) #119. The SSW confirmed that they had forwarded the email to the home's management team. The Director of Care (DOC) shared the home's process was for the Administrator to submit complaints to the Director. The Administrator and DOC verified that there was no records of submission of this written complaint to the Director.

There was no risk to the resident when the complaint was not forwarded to the Director immediately.

Sources: Email communication records; Interviews with complainant, SSW #119, DOC, and Administrator. [s. 22. (1)]

Issued on this 21st day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LUCIA KWOK (752)
Inspection No. / No de l’inspection :	2022_947752_0005
Log No. / No de registre :	018935-21, 018957-21, 019278-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 20, 2022
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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide on the spot education and training to staff and/or visitors not adhering with appropriate IPAC measures.

2. Ensure caddies with personal protective equipment (PPE) are fully stocked at all times.

3. Conduct audits to ensure residents are provided with assistance for hand hygiene (HH) as per best practices. Keep a documented record of the audits conducted, including the date and location of the audit, the person who conducted the audit, and the person who was audited. Analyze the results of the audits and provide further education to any staff who did not adhere to HH practices and assisted residents with HH. Keep a documented record of the additional education provided.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically, related to hand hygiene (HH) practices for residents, universal masking, availability of Personal Protective Equipment (PPE), and donning and doffing the appropriate PPE in additional precaution rooms.

Observations were conducted throughout the inspection and the following were noted:

- A resident room had droplet/contact precaution signage. The PPE caddie outside the room was missing gloves. A visitor in the room did not don face shield and gloves and was delivering lunch tray to the resident.
- A resident room had contact precaution signage. The PPE caddie was missing gowns, and sanitizing wipes.
- Two resident rooms had contact precaution signage. The PPE caddies outside the rooms were missing gloves.
- A resident room had contact precaution signage. After making direct contact with the resident, one staff exited the room and did not change their soiled mask. The staff stated that as there were no active COVID-19 cases so there was no need to change their mask.
- An alcohol-based hand rub (ABHR) bottle outside of a resident room was missing the dispensing pump.
- A contractor was inside a resident room and wore a surgical mask on their chin.
- On several occasions during nourishment pass, staff did not provide HH assistance to residents in their rooms at point of service. Personal Support Worker (PSW) #106 stated that residents received HH before being transported to their room.

Registered Practical Nurse (RPN) #105 stated all staff were responsible to remind visitors and contractors of adherence to the home's IPAC protocols and ensure that PPE caddies were stocked with the required supplies. RPN #107 demonstrated that there was extra PPE supplies in the nursing stations and medication rooms.

The home's IPAC lead and Clinical Quality Educator stated that the expectation was for staff to provide residents with HH at point of service.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was actual risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observations conducted on March 22, and 23, 2022; Interviews with RPN #105, #107, PSW #105; IPAC lead, Clinical Quality Educator and other staff; home's IPAC policies and procedures. [s. 229. (4)]

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

Severity: There was actual risk of harm to the residents because there was actual risk of transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified in multiple resident home areas during the inspection.

Compliance History: In the past 36 months, two WN's and one CO, complied, were issued to the same sub-section of the legislation.
(752)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2022

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 20th day of April, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lucia Kwok

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