



**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
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Telephone: (416) 325-9660
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Bureau régional de services de
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5700, rue Yonge, 5e étage
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2013	2013_102116_0027	T-275- 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), AMANDA WILLIAMS (101)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): June 13, 14, 19, 21, 25, 28 and telephone interviews on June 28, July 2, 3, 2013

Inspector attended the home to conduct an inspection of one critical incident (Log # T-275-13) pertaining to staff to resident physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Long Term Care Services, Director of Care, Police, Registered staff, Personal support workers and family of the resident

During the course of the inspection, the inspector(s) reviewed resident health record, education records on zero tolerance for abuse and responsive behaviour, staff schedules and the following home policies: prevention of abuse, responsive behaviours.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)

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.

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

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that Resident #1 was protected from abuse.

- A review of the clinical health record indicated that upon admission to the home and to date Resident #1 demonstrates aggression towards staff due to a medical condition.
- Interviews with various staff members and personal support worker (PSW) #1 confirmed having knowledge of the resident's aggression and were aware of the current interventions to manage the behaviours.
- On a specified date, Detectives attended the home to inform the Director of Long Term Care Operations that they had reason to believe PSW #1 abused Resident #1.
- The Director of Long Term Care Operations informed the inspector that a video surveillance unknowingly was set up within Resident #1's room by his/her family which recorded an incident of staff to resident abuse. The inspector reviewed the video surveillance and observed that the care rendered by PSW #1 to Resident #1 constituted physical abuse [s. 19. (1)].

2. The Director of Long Term Care Operations confirmed the parties observed on the video are Resident #1 and PSW #1.

Both the Director of Long Term Care Operations and a Police Detective confirmed that observations of video recording demonstrated abuse. The observations made by the inspector, Detective and Director of Long Term Care Operations were in unison.

- Section 96(e) under O.Reg 79/10 requires every licensee of a long term care home to ensure that the written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.
- The homes Abuse policy does not meet these requirements.
- PSW #1 was terminated from the home [s. 19. (1)].



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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).

(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).

(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).

(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).

(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports.

- The licensee's Abuse policy states under role of management "to submit an unusual occurrence report to the Ministry of Health and Long Term Care within 10 working days of the occurrence or sooner in response to requests by the Regional office". The policy does not address the requirement to make mandatory reports under section 24 [s. 20. (2)].



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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 the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

- (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
- (b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
- (c) identifies measures and strategies to prevent abuse and neglect;**
- (d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
- (e) identifies the training and retraining requirements for all staff, including,**
 - (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
 - (ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

Findings/Faits saillants :



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1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

- The licensee's Abuse policy directs staff to ensure that the resident is safe and receives necessary medical care. There are no specific procedures and interventions to assist and support residents who have been abused [s. 96. (a)].

2. - The homes abuse policy does not address required training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care [s. 96. (e)].

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 the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, to be implemented voluntarily.

Issued on this 18th day of September, 2013

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



Ministry of Health and
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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

**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**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SARAN DANIEL-DODD (116), AMANDA WILLIAMS
(101)

Inspection No. /

No de l'inspection : 2013_102116_0027

Log No. /

Registre no: T-275- 13

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Aug 21, 2013

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 : DEBRA COOPER-BURGER

To UNIONVILLE HOME SOCIETY, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
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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

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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 # /

Ordre no : 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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

- The Licensee shall ensure that Resident #1 is protected from abuse by anyone.
- The Licensee shall amend it's Abuse policy to promote zero tolerance of abuse and neglect of all residents to include training and retraining requirements for all staff to meet the policy and training requirements of s. 96 of O.Reg. 79/10.

Grounds / Motifs :



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section 154 of the *Long-Term Care
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de l'article 154 de la *Loi de 2007 sur les foyers
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1. The licensee failed to ensure that Resident #1 was protected from abuse.

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- Interviews with various staff members and personal support worker (PSW) #1 confirmed having knowledge of the resident's aggression and were aware of the current interventions to manage the behaviours.
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- The Director of Long Term Care Operations informed the inspector that a video surveillance unknowingly was set up within Resident #1's room by his/her family which recorded an incident of staff to resident abuse. The inspector reviewed the video surveillance and observed that the care rendered by PSW #1 to Resident #1 constituted physical abuse [s. 19. (1)].

(116)

2. The Director of Long Term Care Operations confirmed the parties observed on the video are Resident #1 and PSW #1. Both the Director of Long Term Care Operations and a Police Detective confirmed that observations of video recording demonstrated abuse. The observations made by the inspector, Detective and Director of Long Term Care Operations were in unison.

- Section 96(e) under O.Reg 79/10 requires every licensee of a long term care home to ensure that the written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff, including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care.
- The homes Abuse policy does not meet these requirements.
- PSW #1 was terminated from the home [s. 19. (1)]. (116)



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

Aug 29, 2013



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section 154 of the *Long-Term Care
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de l'article 154 de la *Loi de 2007 sur les foyers
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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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of August, 2013

Signature of Inspector /

Signature de l'inspecteur : 

Name of Inspector /

Nom de l'inspecteur : SARAN Daniel-Dodd

Service Area Office /

Bureau régional de services : Toronto Service Area Office