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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 27, 29, Jun 15, 2020	2020_722630_0008	006092-20, 006701-20, 009033-20, 010909-20, 011240-20	Critical Incident System

Licensee/Titulaire de permis

Vision '74 Inc.
229 Wellington Street SARNIA ON N7T 1G9

Long-Term Care Home/Foyer de soins de longue durée

Vision Nursing Home
229 Wellington Street SARNIA ON N7T 1G9

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

AMIE GIBBS-WARD (630), MEAGAN MCGREGOR (721)

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): May 27, 28, 29 and June 1, 2, 3, 4, 5, and 8, 2020.

The following Critical Incident (CI) intakes were completed within this inspection:
Log #006092-20 / CI #2659-000003-20 related to allegations of resident abuse;
Log #006701-20 / CI #2659-000004-20 related to falls prevention;
Log #009033-20 / CI #2659-000006-20 related to allegations of resident abuse;
Log #010909-20 / CI #2659-000007-20 related to falls prevention; and
Log #011240-20 / CI # 2659-000008-20 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Care (DOC), the Nurse Manager, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspectors also observed staff interactions with residents, the care being provided to residents and infection prevention and control practices in the home; reviewed clinical records and plans of care for the identified residents; and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **2 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. 30. (1)	CO #902	2020_722630_0008	630

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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident of the home was restrained, by the use of barriers, locks or other devices from leaving a room.

On May 27, 2020, Inspectors #630 and #721 observed specific devices and barriers in place across the doors for multiple residents' rooms.

The clinical records for the residents showed that there were devices and barriers in place across these residents' doors to prevent the residents from leaving their rooms during the COVID-19 Outbreak in the home.

Staff reported that the barriers and devices were in place in order to prevent residents from leaving their rooms due to the COVID-19 Outbreak in the home.

During an interview with a Nurse Manager (NM) they acknowledged that there were devices and barriers in place across doors for residents in the home. The NM said these were in place to help prevent the residents from wandering in the home during the COVID-19 Outbreak. The NM said the home had tried other interventions to help minimize the residents' risk of wandering and these had not been effective. The NM said

the home did not have the staffing resources due to the COVID-19 Outbreak to provide one to one staffing. The NM said they were aware of the legislation prohibiting residents from having barriers to exit their rooms and this was not something they would do under normal circumstances, but due to the extreme situation with COVID-19 the home put this in place for residents.

2. The licensee has failed to comply with Immediate Compliance Order (CO) #901 from inspection #2020_722630_0008 served on May 27, 2020.

The licensee was to be compliant with LTCHA 2007 s. 30(1)5.

Specifically the licensee was to immediately ensure that six identified residents, and any other resident of the home was not restrained, by removing all barriers, locks, tables, dressers and other devices preventing residents from leaving a room.

On May 28 and 29, 2020 Inspectors #630 and #721 observed specific devices and barriers in place across the doors for multiple residents' rooms.

During an interview with Vision Nursing Home Chief Executive Officer (CEO) and the home's Administrator they said they were familiar with Immediate Compliance Order #901. When asked if the home had removed specific devices and barriers in place across the doors of the residents' rooms, they said they had an action plan going forward for these to be removed from doors. They said once they were given clearance from Lambton Public Health Unit (LPHU) that there were no residents in building who were COVID-19 positive, the home would remove the specific devices and barriers. They said they were aware that the specific devices and barriers were still in place across the doors for multiple residents' rooms.

3. The following evidence is further grounds to support Compliance Order (CO) #902 related to LTCHA 2007 s. 30 (1) issued in Inspection #2020_722630_0008 on May 27, 2020, which was to be complied immediately.

The licensee was to be compliant with LTCHA 2007 s. 30(1) and to immediately ensure that six identified residents, and any other resident of the home was not restrained, by removing all barriers, locks, tables, dressers and other devices preventing residents from leaving a room.

The home reported a Critical Incident System (CIS) which documented that an identified

resident had an unwitnessed fall at a specific time and sustained an injury.

Staff reported they had responded to this fall and at the time of the fall this resident had a specific device in place across the door to their room.

During an interview with the Director of Care (DOC) said they were familiar with this resident and their fall with injury. The DOC said based on their investigation of the fall this resident did have a device on their door at the time of the fall. They said they were not sure how long the device had been in place on the resident's door. The DOC said they were aware of CO #901 and acknowledged this resident's device had not been removed in accordance with this immediate order.

Based on these observations, interviews and record reviews the licensee has failed to ensure that no resident of the home was restrained, by the use of barriers, locks or other devices from leaving a room. [s. 30. (1) 5.]

Additional Required Actions:

CO # - 901, 902 were 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure the home was a safe and secure environment for its residents related to screening of essential visitors in accordance with the required Infection Prevention and Control (IPAC) COVID-19 protocols.

Section 86 (1) of the Long Term Care Homes Act, 2007 states "every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home."

In accordance with O. Reg. 79/10, s. 229 (8) (a), the licensee was required to ensure that

there was in place “an outbreak management system for detecting, managing and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans and protocols for receiving and responding to health alerts.”

In accordance with COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 on May 21, 2020, the licensee was required to ensure if an essential visitor was admitted to the home, the following steps were taken: the essential visitor must be actively screened on entry for symptoms and exposures for COVID-19, including temperature checks and not be admitted if they do not pass the screening; the essential visitor must also attest to not be experiencing any of the typical and atypical symptoms.

In accordance with COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes Version 3 dated May 6, 2020, LTCHs were to immediately implement active screening for anyone entering the home (i.e. staff and essential visitors). This screening was to occur twice daily and include symptom screening and temperature checks (i.e., when essential visitors enter and leave the home). The symptoms included in this document were: “new or worsening cough; shortness of breath; sore throat; runny nose, sneezing or nasal congestion (in absence of underlying reasons for symptoms such as season allergies and post nasal drip); hoarse voice; difficulty swallowing; new smell or taste disorder(s); nausea/vomiting, diarrhea, abdominal pain, unexplained fatigue/malaise; chills; headache.” This document also included the question “have you travelled outside of Canada or had close contact with anyone who has travelled outside Canada in the past 14 days?”

On May 27, 28 and 29, June 2, 3, 4 and 5, 2020, Inspectors #630 and #721 observed the home’s active screening of essential visitors. The active screening included a staff member who served as a screener. This staff member completed temperature checks when the visitors entered and left the home and asked the visitors to self-complete a “Vision Nursing & Rest Home COVID-19 Screening Form.” This form included the person’s name, temperature, time in, time out, the person visiting and four questions:
1. Are you presenting with any of the following symptoms? fever, cough, difficulty breathing.
2. Have you travelled to any of the following “hot spots” in the last 14 days? Hubei (including Wuhan) China, Italy, Korea, France, Spain, Germany, Iran.
3. Have you been in contact with a person who has visited those areas in the last 14

days?
4. Have you been in close contact with a person with a confirmed or possible case of COVID-19?
This form did not include a way for the visitors to attest to not be experiencing any of the typical and atypical symptoms. The screener did not ask the visitors to attest to not experiencing symptoms.

On June 5, 2020, the Director of Care (DOC) said the essential visitors allowed entry to the home had been very limited since March 2020 due to COVID-19. The DOC said the home had developed their own tool based on the information from the Ministry of Long-Term Care (MLTC). The DOC said they were not sure if the visitor screening tool had been updated to reflect the May 6, 2020, guidance document related to screening for travel and a broader list of symptoms. [s. 5.]

2. The licensee has failed to ensure that the home was a safe and secure environment for its residents related to smoking safety.

On May 27, 2020, Inspectors #630 and #721 observed residents and staff smoking on patios and balconies in various areas of the home. One resident was observed to have propped open the door leading to the balcony. Smoke was observed to be entering the home through the doorway and a detectable smell of cigarette smoke was noted in the nearby hallway and dining room. Inspectors also observed a resident in the hallway of the home with an unlit cigarette in their mouth.

A review of the Vision Nursing & Rest Home policy titled "Smoking Policy" last revised March 2019, stated "Vision '74 Inc. is designated as a NON-SMOKING home for all residents, employees, volunteers and visitors. The home is bound by the County of Lambton By-Law #10-2004, the Smoke Free Ontario Act 2005 and the Cannabis Act 2018." The policy directed that all smoking materials were controlled by staff. This policy also directed that resident were to smoke in designated smoking areas located in one specific area of the home and staff were to smoke in a different designated areas. The policy stated that all remaining exterior areas of the home were considered non-smoking areas.

Staff reported that residents were temporarily permitted to smoke on balconies in the home due to the active outbreak.

During an interview with an identified resident they reported that they would usually have

to go to the first floor of the home to smoke, but at that time had to go out on the balcony of their home area to smoke. The resident stated they would go out to smoke whenever they felt like it and didn't have to tell staff when they went out.

Clinical records for specific residents documented that these residents had been smoking on the balconies of the home.

On June 2, 2020, the inspectors observed a lighter sitting on a table and a bucket full of cigarette butts floating in water on the covered and enclosed balcony of one of the home areas. At this time the door to the balcony was open and a resident was sitting in the adjacent lounge.

During an interview, when asked about the practices in the home related to smoking, the Director of Care (DOC) stated that it would be identified on admission if a resident smoked and if a resident smoked their cigarettes and lighters were kept locked up by the nurse who would then provide these to residents when they wanted to go out for a smoke. The DOC said there was a specific area on the first floor of the home designated for residents to smoke, but at that time residents were allowed to smoke in an outside area off of each home area due to an active outbreak in the home and being unable to leave their home areas. When asked how the home was ensuring residents' safety related to smoking during this time, the DOC stated that any resident who would not be able to smoke safely would be taken out to smoke by a staff member but that all current residents in the home who smoked were able to smoke safely and independently.

On June 3, 2020, Inspector #721 observed a resident smoking on the covered and enclosed balcony of a home area. The resident's chair was being used to prop the balcony door open. Smoke was observed to be entering the home through the balcony doorway and a detectable smell of cigarette smoke was noted in the nearby hallway and dining room in which a staff member was present at this time. Signage was observed to be posted on the door to the balcony which stated "No smoking. Smoking permitted in designated areas only. Staff smoking area Crawford lot. Resident smoking Brock lot." While travelling back to their room from the balcony a staff member approached the resident and informed them that they were not supposed to smoke on the balcony anymore and had to go to the first floor to smoke.

On June 3, 2020, inspectors observed multiple residents smoking with surgical masks positioned under their chins.

During an interview on June 3, 2020, the DOC told the inspectors that there had been changes to the smoking practices in the home since the previous day and residents were now expected to go to the designated smoking area on the first floor of the home to smoke. The inspectors discussed with the DOC that residents had been observed throughout the course of the inspection to be wearing surgical masks around their chins while smoking. When asked what the expectations in the home were related to residents wearing masks while smoking, the DOC said residents were expected to wear a mask while travelling through the home to the designated smoking area but not while smoking.

On June 5, 2020, signage which stated “No smoking. Smoking permitted in designated areas only. Staff smoking area Crawford lot. Resident smoking Brock lot” was observed to be posted on all doors leading to balconies and patios on each home area. Signage was also observed on the door leading to a patio beside the main entrance to the home which stated “Resident smoking area.”

The licensee has failed to ensure that the home was a safe environment for all residents due to the safety risks related to resident's smoking practices and the inconsistent implementation of the home's smoking policy by staff and for specific residents. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that staff to resident neglect had occurred that resulted in risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) for an alleged staff to resident neglect that had occurred on specific dates. This report documented that the MLTC after hours pager had not been contacted by the home about this incident. The report showed there was a three day period between when the investigation had been initiated and when the report had been submitted to the MLTC.

During an interview one of the residents identified in the CIS report, told Inspector #630 that they had spoken to the Director of care (DOC) because there was a specific staff member who had not provided the care they required.

The home’s investigation documentation included details of the residents’ allegations and interviews that had been completed with staff. The documentation showed the home’s investigation had been completed prior to the home submitting the CIS report to the MLTC.

The home's policy titled "Abuse of a Resident 125-VI-91B" with last revision date January 2019 included: "Reporting Requirements in the Nursing Home: The Ministry of Health and Long-Term care Critical Incident Reporting must be initiated and reported immediately by the NH Director of care/Administrator or delegate. After hours the Compliance Inspector on call must be notified. The report will be amended as required and upon completion of the investigation."

During an interview the DOC said the expected process in the home for reporting allegations of staff to resident abuse or neglect to the MLTC was once the investigation had taken place then it was reported that day within 24 hours.

Based on interviews and record review, the licensee has failed to ensure that a person who had reasonable grounds to suspect that staff to resident neglect had occurred, immediately reported the suspicion and the information upon which it was based to the Director. The allegations of staff to resident neglect were not report to the Director until after the investigation had been completed. [s. 24. (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 any person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who was unable to toilet independently some or all of the time, received the assistance required from staff to manage their urinary continence.

The home submitted a Critical Incident System (CIS) report which included details of a concern by a resident regarding the continence care they had received by a Personal Support Worker (PSW) on a specific date.

During an interview this resident told Inspector #630 that they required a specific type of assistance from staff with their continence care. The resident had concerns that sometimes staff did not respond in a timely way when they rang for continence care assistance.

The resident's clinical record showed they required a specific type of assistance from staff for continence care.

During an interview the Director of Care (DOC) said this resident required a specific type of assistance from staff with continence care. The DOC said when they interviewed a specific staff member they had verified that this resident had not received the continence care they required on specific shifts.

Based on the interviews and record review this resident did not receive the continence care assistance they required from staff. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

Issued on this 16th day of June, 2020

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), MEAGAN MCGREGOR (721)
Inspection No. / No de l'inspection :	2020_722630_0008
Log No. / No de registre :	006092-20, 006701-20, 009033-20, 010909-20, 011240-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 27, 29, Jun 15, 2020
Licensee / Titulaire de permis :	Vision '74 Inc. 229 Wellington Street, SARNIA, ON, N7T-1G9
LTC Home / Foyer de SLD :	Vision Nursing Home 229 Wellington Street, SARNIA, ON, N7T-1G9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Virginnia Bright

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

To Vision '74 Inc., 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

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

Order # / No d'ordre : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 30(1)5.

Specifically the licensee must:

Immediately ensure that six identified residents, and any other resident of the home, are not restrained, by removing all barriers, locks, tables, dressers and other devices preventing residents from leaving a room.

Grounds / Motifs :

1. The licensee has failed to ensure that no resident of the home was restrained, by the use of barriers, locks or other devices from leaving a room.

On May 27, 2020, Inspectors #630 and #721 observed specific devices and barriers in place across the doors for multiple residents' rooms.

The clinical records for the residents showed that there were devices and barriers in place across these residents' doors to prevent the residents from leaving their rooms during the COVID-19 Outbreak in the home.

Staff reported that the barriers and devices were in place in order to prevent residents from leaving their rooms due to the COVID-19 Outbreak in the home.

During an interview with a Nurse Manager (NM) they acknowledged that there were devices and barriers in place across doors for residents in the home. The NM said these were in place to help prevent the residents from wandering in the home during the COVID-19 Outbreak. The NM said the home had tried other interventions to help minimize the residents' risk of wandering and these had not been effective. The NM said the home did not have the staffing resources due to the COVID-19 Outbreak to provide one to one staffing. The NM said they were aware of the legislation prohibiting residents from having barriers to exit their rooms and this was not something they would do under normal circumstances, but due to the extreme situation with COVID-19 the home put this in place for residents.

The severity of the issue was determined to be a level 4 as there was immediate risk to the residents. The scope of the issue was determined to be level 2 as it related to a pattern of residents in the home. The home had a level 2 compliance history as they had previous non-compliance with a different sub-section in the last 36 months. (630)

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

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

Order # / No d'ordre : 902

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

Linked to Existing Order / Lien vers ordre existant: 2020_722630_0008, CO #901;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee must be compliant with LTCHA 2007 s. 30(1)5.

Specifically the licensee must:
Immediately ensure that two identified residents, and any other resident of the home, are not restrained, by removing all barriers, locks, tables, dressers and other devices preventing residents from leaving a room.

Grounds / Motifs :

1. The licensee has failed to comply with Immediate Compliance Order (CO) #901 from inspection #2020_722630_0008 served on May 27, 2020.

The licensee was to be compliant with LTCHA 2007 s. 30(1) 5.

Specifically the licensee was to immediately ensure that six identified residents, and any other resident of the home was not restrained, by removing all barriers, locks, tables, dressers and other devices preventing residents from leaving a room.

On May 28 and 29, 2020 Inspectors #630 and #721 observed specific devices and barriers in place across the doors for multiple residents' rooms.

During an interview with Vision Nursing Home Chief Executive Officer (CEO) and the home's Administrator they said they were familiar with Immediate Compliance Order #901. When asked if the home had removed specific devices and barriers in place across the doors of the residents' rooms, they said they had an action plan going forward for these to be removed from doors. They said once they were given clearance from Lambton Public Health Unit (LPHU) that there were no residents in building who were COVID-19 positive, the home would remove the specific devices and barriers. They said they were aware that the specific devices and barriers were still in place across the doors for multiple residents' rooms.

The severity of the issue was determined to be a level 4 as there was immediate risk to the residents. The scope of the issue was determined to be level 2 as it related to a pattern of residents in the home. The home had a level 4 compliance history as they had a re-issued Compliance Order (CO) to the same subsection. (630)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2020

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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
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.

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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 27th day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amie Gibbs-Ward

Service Area Office /
Bureau régional de services : London Service Area Office