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
Apr 1, 2021	2021_605213_0007	002923-21, 004258-21	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

RHONDA KUKOLY (213), INA REYNOLDS (524)

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): March 29 and 30, 2021

The following intakes were inspected:
Log #002923-21, Critical Incident #2659-000003-21, related to a fall.
Log #004258-21, Critical Incident #2659-000006-21, related to a COVID-19 outbreak

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Practical Nurses, Personal Support Workers, Housekeepers and residents.

The inspectors also made observations and reviewed health records, policies and procedures, communication in the home and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to two residents as specified in the plan.

A) A critical incident documented that a resident had a fall where the resident sustained an injury resulting in a significant change in their health status. The care specified in the plan of care was not completed which contributed to the fall.

A staff member said the fall happened very fast and they did not complete the care as specified in the plan. The Director of Care (DOC) acknowledged that staff should have provided the care as set out in the plan of care. The staff not following the care plan resulted in harm as the resident was injured from the incident.

Sources: A Critical Incident Report System (CIS) report, a resident's clinical records; and, interviews with the DOC and a Personal Support Worker (PSW).

B) Observation and interview with a PSW noted two quarter bedrails on another resident's bed in the raised position at the head of the bed. Review of the most recent plan of care and bedside logo documented the resident was at high risk for falls and required one bedrail engaged for safety.

A registered staff member reviewed the care plan with inspector and acknowledged that the care plan stated one full bedrail as a Personal Assistive Service Device (PASD) for resident safety and transfers. The staff not following the plan of care placed the resident at an increased safety risk.

Sources: A resident's clinical records; and, interviews with a registered staff member and a PSW. [s. 6. (7)] (524)

2. The licensee has failed to ensure that the plan of care for resident was reviewed and revised when a resident's care needs changed.

A resident had an unwitnessed fall. Risk Management interventions in the resident's post-fall assessment documented an intervention was to be used.

Observation and interview with a PSW noted the intervention was in use. Review of the resident's plan of care and bedside logo showed there was no reference to the intervention.

A registered staff member said that the resident was at high risk for falls. The intervention was in use as an intervention to minimize the impact of a potential fall. They acknowledged the plan of care was not revised to the include the intervention. This placed the resident at risk for not receiving the fall interventions they needed.

Sources: A resident's clinical records; and, interviews with a registered staff member and a PSW. [s. 6.(10) (b)] (524)

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 care set out in the plan of care is provided to residents as specified in the plan and to ensure that the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

Issued on this 13th day of April, 2021

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

Original report signed by the inspector.