Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 11, 2023	
Inspection Number: 2023-1165-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Vision '74 Inc.	
Long Term Care Home and City: Vision Nursing Home, Sarnia	
Lead Inspector Debra Churcher (670)	**Inspector Digital Signature** Debra Churcher Digitally signed by Debra Churcher Date: 2023.10.19 14:41:41 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3, 4, 5, 2023

The following intake(s) were inspected:
- Intake: #00089224 – CIS# 2659-000018-23 related to a fall with injury.
- Intake: #00092561 – CIS# 2659-000024-23 related to a missing resident.
- Intake: #00093000 - Complaint related to a missing resident.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary:
Review of the resident's kardex stated the resident was to receive an intervention at specific intervals.

Review of the resident's electronic care plan stated the resident was to receive the intervention at specific intervals that differed from the Kardex.

Review of a resident's point of care task documentation stated the resident was to receive the intervention at specific intervals that differed from the Kardex.

During an interview with the Director of Care (DOC) they acknowledged that the Kardex, electronic care plan and point of care task documentation were all part of the residents plan of care and should provide consistent direction.

Failure to ensure the resident's plan of care provided clear direction related to the timing of specific interventions placed the resident as risk.

Sources:
Review of a resident's clinical record and interview with the DOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

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

Rationale and Summary:
Observation of a resident showed the resident utilized specific equipment.

During an interview with a Personal Support Worker (PSW) they stated that this equipment was implemented after a prior incident and was used at specific times during the day.

Review of the resident's plan of care did not show the use of the equipment.

During an interview with the Director of Care (DOC) they acknowledged the plan of care was not updated to reflect the need for the use of the equipment.

Failure to ensure the resident's plan of care included the equipment placed the resident at risk.

Sources:
Interview with the DOC and a PSW, observation of the resident and review of the resident's clinical record.

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COMPLIANCE ORDER CO #001 Safe and Secure Home

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically the licensee must:
-Develop a procedure to ensure that any staff member resetting the safety system once it has been activated is aware of the identity of the resident that triggered the system and has ensured the residents presence in the home.
--Educate all staff to the developed procedure.
-Keep a log of the safety system that includes the date, time, location, resident that triggered the system and the staff member that reset the system.
-The log must be accessible to all staff that have the authority to reset the system.

-The DOC or delegate shall review the safety system logs weekly to ensure that staff are following the developed procedure and will take corrective action if required.
-Keep records of the safety system logs and proof of education on site and readily available.

Grounds
The licensee has failed to ensure that the home was a safe and secure environment for a resident.

Rationale and Summary:
Review of the home investigation file showed that a resident was not under the care or supervision of the home and staff were unaware. A safety system was activated and reset by a staff member without verification of the resident's whereabouts. Upon return to the home, the resident required additional medical intervention.

During an interview with a staff member they stated that when a resident with a safety system in place moved near an exit, or elevator on the second floor, an alarm would ring and the exit doors would lock. Staff were required to enter a code into the panel to turn off the alarm and reset the doors. If the doors were open at the time, the safety system would not lock the doors. The staff also stated that staff required to reset the alarm are not always aware of what resident triggered the alarm

During an interview with the Director of Care (DOC) they acknowledged that staff who were resetting the safety system were not always aware of what resident triggered the safety system.

Re-setting the safety system without knowing the resident's whereabouts in the facility placed all residents that required the safety system at risk.

Sources:
The home’s investigation file and interview with a staff member and the DOC.

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This order must be complied with by October 21, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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