Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 14, 2016	2016_457630_0039	031034-16	Resident Quality Inspection

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), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 31, November 1, 2, 3 and 4, 2016.

The following concurrent inspection was conducted within this Resident Quality Inspection (RQI):
Critical Incident Log #022096-16/CI 2659-00003-16 - related to falls prevention.

Inspectors Chris Laidlaw and Debora Churcher were also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nurse Manager, the Social and Administrative Services Manager, the RAI-MDS Coordinator, five Registered Practical Nurses (RPN), eight Personal Support Workers (PSWs), three family members and over twenty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 there was a written plan of care for the resident that set out the planned care for the resident.

An identified resident was observed in a specific device.

Interview with an identified staff person indicated that the specified device was used for this resident.

During an interview with a different staff person it was reported that this specific device

was not to be used for this resident as the the Substitute Decision Maker (SDM) declined consent due to risks.

Review of the plan of care for this identified resident showed no direction provided to staff regarding the specified device including no indication that the resident should not be using the device due to risks.

The Director of Care (DOC) stated that the specified device should not have been used as it was not included in the plan of care for this resident. [s. 6. (1) (a)]

2. Multiple observations found a specific device was being used for an identified resident.

Interview with a staff member of the home indicated that they were unsure without looking at the logo what device was being used for this resident.

Review of the logo indicated different instructions for the specific device than what was being used for this resident.

Review of the care plan on the computer for this resident did not indicate use of this specific device.

Interview with the DOC stated that the specific device used for the resident should be consistent with the logo and should be documented in the plan of care to ensure that the staff have clear direction. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in continence care for the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A specific resident was observed to show visible signs of incontinence.

A staff member reported that this resident was incontinent on a regular basis and wore a specific continence care product.

Another staff member reported that this specific resident was incontinent of urine and would often soak through the product especially during the night. This staff member said they would look in the electronic plan of care to determine a resident's continence status

and which continence care products were required.

Review of the continence product list showed a different product was listed compared to the electronic plan of care.

Further review of the clinical record showed there had been a request for assessment for the change of continence care product used by this resident but the assessment was not completed.

During an interview with the DOC it was reported that the process for assessing continence care for residents in the home included RAI MDS assessments, the interdisciplinary care conference meetings and then the registered staff working on the unit were responsible for updating the plan of care. DOC stated that the process in the home to change the continence care product in a plan of care for a resident would involve a continence referral progress note and then a specific staff member would assess and update the plan of care. DOC stated that any staff person could update the plan of care for continence care. Reviewed the plan of care and assessment notes for this specific resident with the DOC and it was acknowledged that there was not collaboration and communication across disciplines for the assessment of the continence care for this resident. DOC also acknowledged that the staff did not collaborate in the development and implementation of the plan of care. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Record review for a specified resident revealed a care plan that indicated the resident a specific device was used to support proper positioning.

Interview with a staff member in the home indicated that the resident no longer used this specific device as the SDM had indicated they no longer consented to this.

Interview with a staff member indicated that the resident no longer used this specific device for positioning.

The DOC stated that the plan of care should have been updated to reflect the change to ensure staff had clear direction. (537) [s. 6. (10) (b)]

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 by ensuring the written plan of care that sets out the planned care for the resident, the plan of care provides clear direction to staff and others who provide direct care, the plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary and the staff and others involved in collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy and procedure the home had put in place for the use of physical restraints in the home was complied with.

Multiple observations during the inspection observed that an identified resident was using a specific device.

Multiple staff members in the home reported that they they used the specified device for this resident and the use of this device did potentially affect the resident's ability to get out of the chair.

Another staff member reported they did not know that this specific device was being used for this resident. This staff member also said that the process in the home when a potential restraint,such as this specific device, was initiated was to obtain a physician's order, consent from the family, add it into the electronic Medication Administration Record (eMAR) and update the plan of care prior to implementing this intervention.

Review of the clinical record for this specific resident identified that this specific device was considered a restraint, there was no relevant assessment completed, it had not been added to the eMAR and there was no documentation in the progress notes by registered staff regarding this device.

Review of the home's policy tilted "Restraints" with "Policy Number 550-R-10A" and last "revision Date 12/14" stated the following:
- "Before any restraint is used the Registered Nursing Staff must investigate the reason and alternative methods" and "The nurse must complete the Restraint/PASD Assessment in PCC"
- "Once the Physician/RNEC order is received, the consent and restraint assessment is completed; the Registered Staff must document in the multidisciplinary notes in PCC every eight hours to evaluate the restraint need, resident observations and behaviour, resident condition and the need to continue."

During an interview with the Director of Care (DOC) it was reported that it was the expectation in the home that the policy related to restraints would be followed including the completion of the relevant assessments. The DOC also indicated that it was the procedure in the home for the plan of care and eMAR to be updated to provide clear direction for staff related to the use of restraints. Reviewed the clinical record for this identified resident with the DOC and it was acknowledged that the home's policy had not been complied with regarding the specified device which the home did consider to be a restraint for this resident. [s. 8. (1) (b)]

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 by ensuring that the policy and procedure the home put in place for the use of physical restraints in the home is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Multiple observations during the inspection observed that an identified resident was using a specific device.

Multiple staff members in the home reported that they they used the specified device for this resident and the use of this device did potentially affect the resident's ability to get out of the chair.

Another staff member reported they did not know that the tilt function on the wheelchair was being used for resident #001 as it did not appear in the electronic Medication Administration Record (eMAR). This staff member reported that they had not assessed the restraint for this resident.

Review of the clinical record for this identified resident showed there was no documentation in the eMAR or progress notes by registered staff related to reassessment of the restraint.

During an interview with the Director of Care (DOC) reported that it was the expectation in the home that the registered staff reassess the resident at least every shift when a physical restraint was being used. Reviewed the clinical record for this resident with the DOC and it was acknowledged that the registered staff had not been monitoring or reassessing the restraint after the order was received from the physician. [s. 110. (2) 6.]

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 by ensuring that the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

Issued on this 17th day of November, 2016

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

Original report signed by the inspector.