

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) /	Inspection No /	Log # /	Type of Inspection /
Date(s) du apport	No de l'inspection	No de registre	Genre d'inspection
Oct 23, 2017	2017_262630_0029	023650-17	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), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection



Ontario

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

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

This inspection was conducted on the following date(s): October 16, 17, 18, 19 and 20, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):

Complaint Log #029952-16/IL-47319-LO related to infection prevention and control; Complaint Log #021221-17/IL-52718-LO related to personal support services; Complaint Log #004476-17/IL-49567-LO related to personal support services.

Critical Incident Log #031713-16 for Critical Incident System (CIS) report 2659-000004-16 related to falls prevention;

Critical Incident Log #010461-17 for Critical Incident System (CIS) report 2659-000002-17 related to falls prevention;

Critical Incident Log #016596-17 for Critical Incident System (CIS) report 2659-000004-17 related to falls prevention;

Critical Incident Log #021471-17 for Critical Incident System (CIS) report 2659-000005-17 related to falls prevention.

London Service Area Office (LSAO) Inspection Manager #688 (Kevin Bachert) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Resident Assessment Instrument (RAI) Coordinator, the Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Recreation Aide, 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 various policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Falls Prevention Infection Prevention and Control Medication Minimizing of Restraining Nutrition and Hydration Personal Support Services Residents' Council Skin and Wound Care

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

1 WN(s) 0 VPC(s) 0 CO(s) 0 DR(s) 0 WAO(s)



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007 Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES			
Legend	Legendé		
 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order 	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).	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.		



Ministry of Health and Long-Term Care Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007 Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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).

Findings/Faits saillants :

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

A family member for an identified resident told an inspector they had concerns that the resident was not receiving the care they required related to a specific device.

This identified resident told an inspector that there were times when they did not receive the care they required related to a specific device.

The plan of care for this identified resident included that this resident required specific care related to this device.

The Director of Care (DOC) said that they were aware that the family for this identified resident had concerns about the care provided related to the specific device. The DOC said they looked into the concern and found that staff had documented that the care had been provided to this identified resident and this documentation was incorrect as the care had not been provided. The DOC said it was the expectation in the home that the staff would provide the care as per the plan of care and that this would be reflected in the documentation.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 31, 2016, in Resident Quality Inspection (RQI) #2016_457630_0039 as a Voluntary Plan of Correction (VPC). [s. 6. (7)]



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

Issued on this 26th day of October, 2017

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

Original report signed by the inspector.