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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2022	2022_896745_0002	000368-22, 000459-22	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

CHERYL MCFADDEN (745), CHRISTINA LEGOUFFE (730)

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): January 18, 19 and 20, 2022.

The following Critical Incident (CI) intakes were completed within this inspection:
Log# 000368-22 related the unexpected death of a resident.
Log# 000459-22 related to falls prevention.

An IPAC inspection was also completed as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered Nurse (RN), two Registered Practical Nurses (RPN), two Personal Support Workers (PSW), a housekeeper and a screener.

The inspectors also made observations of infection and prevention control practices, reviewed resident's clinical records, Critical Incident System reports, policies and procedures related to inspection topics and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 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 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 home's "Head Injury Routine" (HIR) policy was complied with for three residents.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's "Head Injury Routine" policy 550-H-15-A (revised November 2021), which stated that, "Any resident who receives a blow to the head e.g. striking head during a fall, must receive immediate attention to assess the neurological status with appropriate documentation on the Head Injury Routine (Form #550-554).

HIRs were to be completed every 30 minutes for two hours, every hour for four hours, and every two hours for eight hours.

A resident sustained a fall, and staff had concern that the resident had hit their head, and an HIR was initiated. On multiple occasions the assessment was not completed and was either documented as "missed" or left blank.

On a later date the resident was found with injuries, was suspected to have had a fall, and an HIR was initiated. On multiple occasions the assessment was not completed and was either documented as "missed" or left blank.

A Registered Practical Nurse (RPN) said that HIRs were to be completed for all unwitnessed falls or when it was suspected that a resident hit their head. They said that all checks should be completed and that the HIRs for the resident were not completed for either date. [s. 8. (1)]

2. A second resident sustained an unwitnessed fall and an HIR was initiated. Multiple checks were not completed or were documented as missed and the resident's pupils were not assessed on some occasions and it was documented that the resident was sleeping.

The Director of Care (DOC) said that they would expect a resident to be woken up so that an HIR could be completed and that the HIR for the resident was not completed as per their expectations. [s. 8. (1)]

3. A third resident sustained an unwitnessed fall and a HIR was initiated. Some checks were not completed or were documented as missed and the resident's pupils were not assessed on multiple occasions and it was documented that the resident was sleeping.

The Director of Care (DOC) said that the HIR for the resident was not completed as per their expectations.

The homes failure to complete the HIRs for the three residents placed the residents at risk for harm.

Sources: "Head Injury Routine" policy (revised November 2021), clinical records for three residents including progress notes and head injury routine documentation; and interviews with an RPN, the DOC, and other staff. [s. 8. (1)] (730)

Additional Required Actions:

CO # - 001 will be 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care related to personal assistance service devices (PASDs) provided clear directions to staff and others who provided direct care to the resident.

A review of the progress notes and assessments for a resident indicated that the resident used two devices. The plan of care for the resident did not include the devices, indicate the purpose for use or give directions for staff on how or when to apply them.

A Registered Practical Nurse (RPN) said that the resident used the devices as Personal Assistive Service Devices (PASDs), as they were able to remove them independently. They said that the PASDs should have been included in the resident's plan of care and that clear direction was not provided for staff and others who provided direct care to the resident.

The Director of Care (DOC) said that the resident used the devices as PASDs and that they were unsure of when the resident started using them. They also said that the PASDs should have been included in the resident's plan of care and provided clear directions for staff.

There was a risk of harm to the resident due to their plan of care not providing clear direction related to PASDs.

Sources: Clinical records for a resident including progress notes, assessments, and interviews with an RPN and other staff. [s. 6. (1) (c)] (730)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed immediately of the unexpected death of a resident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC), which categorized the death of a resident as unexpected.

The Director of Care (DOC) said they were aware of the incident and the report was not submitted immediately.

Sources: CIS report #2659-000001-22, interview with DOC. [s. 107. (1) 2.]

Issued on this 28th day of January, 2022

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

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Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	CHERYL MCFADDEN (745), CHRISTINA LEGOUFFE (730)
Inspection No. / No de l’inspection :	2022_896745_0002
Log No. / No de registre :	000368-22, 000459-22
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 28, 2022
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

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

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10 s. 8 (1) (b).

Specifically,

A) All residents who have a head injury or unwitnessed fall have a head injury routine completed as per the home's head injury routine policy.

B) The home will complete re-education with all registered staff members related to the home's head injury routine policy. A record must be kept of the re-education, including the dates of the training and the names of the staff members who completed the training.

C) Complete weekly audits of the Head Injury Routine assessments that were completed on each home area. Audits will be completed for a minimum of three months or until the order is complied. Keep a written record of the weekly audit and include the name of the resident, the name of the person completing the audit, the outcome of the audit and corrective action if necessary.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's "Head Injury Routine" (HIR) policy was complied with for three residents.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to

reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's "Head Injury Routine" policy 550-H-15-A (revised November 2021), which stated that, "Any resident who receives a blow to the head e.g. striking head during a fall, must receive immediate attention to assess the neurological status with appropriate documentation on the Head Injury Routine (Form #550-554).

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(730)

2. A second resident sustained an unwitnessed fall and an HIR was initiated. Multiple checks were not completed or were documented as missed and the resident's pupils were not assessed on some occasions and it was documented that the resident was sleeping.

The Director of Care (DOC) said that they would expect a resident to be woken up so that an HIR could be completed and that the HIR for the resident was not

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3. A third resident sustained an unwitnessed fall and a HIR was initiated. Some checks were not completed or were documented as missed and the resident's pupils were not assessed on multiple occasions and it was documented that the resident was sleeping.

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The homes failure to complete the HIRs for the three residents placed the residents at risk for harm.

Sources: "Head Injury Routine" policy (revised November 2021), clinical records for three residents including progress notes and head injury routine documentation; and interviews with an RPN, the DOC, and other staff. [s. 8. (1)] (730)

An order was made by taking the following factors into account:

Severity: Head Injury Routine assessments were incomplete for three residents after that had a fall or suspected fall. This put the residents at risk as staff had the potential to miss post fall injuries.

Scope: The scope of this non-compliance was widespread as the home's Fall Head Injury Routine policy was not complied for three out of three residents reviewed.

Compliance History: There was no previous noncompliance to this section of O. Reg. 79/10.

(730)

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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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Apr 01, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 28th day of January, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cheryl McFadden

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