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

**London Service Area Office**
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
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**Original Public Report**

**Report Issue Date** July 13, 2022
**Inspection Number** 2022_1165_0001
**Inspection Type**
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________

**Licensee**
Vision '74 Inc.

**Long-Term Care Home and City**
Vision Nursing Home Sarnia

**Lead Inspector**
Melanie Northey (563)

**Inspector Digital Signature**

## INSPECTION SUMMARY

The inspection occurred on the following date(s): June 27, 28, 29, 30 and July 4 and 5, 2022

The following intake(s) were inspected:

- Intake # 006791-22 (CIS # 2659-000006-22) related to fall prevention and management
- Intake # 007310-22 (CIS # 2659-000007-22) related to fall prevention and management
- Intake # 001753-22 (Follow-up) to inspection #2022_896745_0002 for Compliance Order (CO) #001 with Compliance Due Date (CDD) April 1, 2022 for O. Reg. 79/10, s. 8 (1) (b)

**Previously Issued Compliance Order(s)**

The following previously issued Compliance Order(s) were found to be in compliance.

| Legislative Reference | | Inspection # | Order # | Inspector (ID) who complied the order |
|---|---|---|---|---|
| O. Reg. 79/10 | s. 8 (1) (b) | 2022_896745_0002 | 001 | 563 |

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

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- Safe and Secure Home

## INSPECTION RESULTS

### NON-COMPLIANCE REMEDIED

***Non-compliance*** was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**NC#001 remedied pursuant to FLTCA, 2021, s. 154 (2)**

O. Reg. 246/22 [s. 102 (2)(b)]

The Environmental Service Manager (ESM) was observed entering a resident's room pushing a trolly with gloves on, continued to wear the same disposable gloves throughout the Ontario home area, walking past residents and into the elevator to first floor, and did not perform hand hygiene or change the gloves at any time between tasks or resident environments. The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (LTCHs) identified the four moments of hand hygiene to include before initial resident/resident environment contact and after resident/resident environment contact. The Administrator spoke to the ESM and there were no further concerns observed related to glove use and hand hygiene.

There were four wall mounted dispensers of alcohol-based hand rub (ABHR) expired April 2022, no one was seen using these before or after point of care tasks. The home replaced the ABHR immediately when it was brought to their attention and updated their audit and role responsibility process to have a designated person responsible for checking the expiry dates of wall mounted ABHR. Although one of the pumps was located in a resident room, it was not observed used as there was one mounted outside the room that staff used.

Sources: observations of the ESM and nursing staff, review of ESM education/orientation related to IPAC, review of the IPAC Standard for LTCHs and the Hand Hygiene Policy.

Date Remedy Implemented: July 5, 2022 [563]

**NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)**

O. Reg. 246/22 [s. 11 (1)(a)]

Review of the Hand Hygiene Program Policy #350-IV-10A last revised December 2021 documented, "Preferred Method of Hand Hygiene: Alcohol-based Hand Rubs: Using alcohol-based hand rub is the preferred method for decontaminating hands when they are not visibly soiled. Contain a variety of alcohols in concentrations from a minimum of 60-90%". The policy was revised June 2022 to "Contain a variety of alcohols in concentrations from a minimum of 70-90%".

Sources: Hand Hygiene Program Policy #350-IV-10A and interview with the IPAC Manager.

Date Remedy Implemented: June 30, 2022 [563]

## WRITTEN NOTIFICATION [PLAN OF CARE]

**NC#003 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 the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

**Rationale and Summary**

A resident sustained a fall and injuries and a Minimum Data Set (MDS) assessment and a Physiotherapy assessment was completed that identified the resident as requiring increased staff assistance for care due to a deterioration in their physical status and participation in activities of daily living (ADLs).

The Point Click Care (PCC) care plan was reviewed and revised but was not updated in full to reflect the changes to the resident's care needs. A Registered Practical Nurse reviewed the bed side logo system and PCC care plan to verify the plan of care was not revised when the resident's needs changed.

The "Return from Hospital Nursing Assessment" documented ADLs and continence care levels (CCLs) had been re-assessed and care plan updated. ADLs and CCLs were not updated as part of the PCC care plan or the bedside logo system.

The Director of Care (DOC) stated it was the expectation that the plan of care be revised to reflect the current care delivered to the resident, especially a change in the plan of care that could put the resident at continued risk of falls. The DOC verified the plan of care was not revised when there was a change in ADL and CCL function.

The plan of care was not revised to include the current interventions for ADLs and CCLs. Staff relied on the plan of care to provide consistent and safe care to the resident.

Sources: resident's clinical record, observations of the resident, and staff interviews.
[563]

## WRITTEN NOTIFICATION [AIR TEMPERATURE]

**NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 [s. 24 (2)]**

The licensee has failed to ensure that the temperature was measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home, and one

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resident common area on every floor of the home, which may include a lounge, dining area or corridor.

**Rationale and Summary**
The Building Temperature Monitoring Policy #300-VI-63A last revised May 2022 documented, "Building temperatures must be measured and documented as required by the Ministry of Health and LTC at a minimum in the following areas of the home: 2 Resident Rooms (2 different areas of the home), 1 Resident Common Area on each floor and 1 designated cooling area, if there are any in the home. This is done by monitoring the Building Automation System (BAS) for the 2-story building and manual thermostat checks in the 3-story building." "Maintenance will perform Morning and Afternoon checks on regular business days Monday-Friday. Charge RN will do the checks on Nights 7 days a week and all checks on Saturday/Sunday and holidays."

The Building Temperature Weekly Log documented instructions that, "If building temperature reaches 26 degrees Celsius (°C) or above for 3 consecutive shifts complete log (Form 300-325F) and contact Maintenance Supervisor." The air temperature documentation May 12 - June 3, 2022, included different resident rooms in different home areas, and the Michigan, Erie, Superior, and Ontario home care area lounges. The building temperatures were not documented for resident rooms and lounges for entire days and shifts between May 12 and June 30, 2022, for multiple entries.

The Director of Care (DOC) verified there were multiple times where the air temperature in a resident's room reached 26 (°C) or above during a specific time with no monitoring of the room temperature for the remainder of the day and the following day.

The Administrator stated the missing documented temperatures for morning and afternoon was done by the Maintenance Manager Monday to Friday by checking the Building Automation System (BAS), but for resident rooms and the Ontario and Michigan lounges, the Maintenance Manager or the Registered Nurse would have to go to the resident rooms to check manually and this was not done or documented. The Administrator verified there were several entries in a row where there was no documentation to identify a possible air temperature concern and the home would not know if the heat related illness prevention and management plan should be implemented anytime the temperature in an area in the home reached 26 (°C) or above.

Temperatures were not measured and documented in writing in at least two resident bedrooms and the lounge areas on every floor of the home. The home would not have known when to implement their heat related illness prevention and management plan putting residents at risk for dehydration, delirium, and increased fall risk.

Sources: Building Temperature Monitoring Policy #300-VI-63A, Building Temperature Weekly Logs, observations of thermostats, and staff interviews.
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## WRITTEN NOTIFICATION [AIR TEMPERATURE]

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**NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 [s. 24 (3)]**

The licensee has failed to ensure temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

**Rationale and Summary**
The Building Temperature Monitoring Policy #300-VI-63A last revised May 2022 documented, "Building temperatures must be measured and documented as required by the Ministry of Health and LTC … these temperatures must be recorded three times daily at the following times: Morning 6am-9am, Afternoon 12pm-5pm, Night 11pm-4am".

The Building Temperature Weekly Log documented instructions that, "If building temperature reaches 26 degrees Celsius (°C) or above for 3 consecutive shifts complete log (Form 300-325F) and contact Maintenance Supervisor." The air temperature documentation May 12 - June 3, 2022, included different resident rooms in different home areas, and the Michigan, Erie, Superior, and Ontario home care area lounges. There were multiple entries that had no documentation related to building temperatures and entire days and shifts at the times required.

The Director of Care (DOC) verified there were multiple times where the air temperature in a resident's room reached 26 (°C) or above during a specific time with no monitoring of the room temperature for the remainder of the day and the following day.

The Administrator stated the missing documented temperatures for morning and afternoon was done by the Maintenance Manager Monday to Friday by checking the Building Automation System (BAS), but for resident rooms and the Ontario and Michigan lounges, the Maintenance Manager or the Registered Nurse would have to go to the resident rooms to check manually and this was not done or documented. The Administrator verified there were several entries in a row where there was no documentation to identify a possible air temperature concern and the home would not know if the heat related illness prevention and management plan should be implemented anytime the temperature in an area in the home reached 26 (°C) or above.

Temperatures were not measured under subsection (2) or documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night on multiple days and shifts. The home would not have known when to implement their heat related illness prevention and management plan putting residents at risk for dehydration, delirium, and increased fall risk.

**Sources:** Building Temperature Monitoring Policy #300-VI-63A, Building Temperature Weekly Logs, observations of thermostats, and staff interviews.
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