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
londondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 26, 2023
Inspection Number: 2022-1165-0003
Inspection Type: Complaint Critical Incident System
Licensee: Vision '74 Inc.
Long Term Care Home and City: Vision Nursing Home, Sarnia

Lead Inspector	**Inspector Digital Signature**
Debra Churcher (670)	Debra Churcher Digitally signed by Debra Churcher Date: 2023.02.01 08:57:52 -05'00'

Additional Inspector(s)
Tatiana Pyper (733564)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 15, 16, 20, 21, 22, 28, 29, 30, 2022, January 3, 4, 6, 9, 2023.

The following intake(s) were inspected:

- Intake: #00001522-IL-04266-LO Complainant related to concerns regarding responsive behaviours.
- The following intakes were completed in this inspection: Intake #00002618, CI#2659-000017-22, Intake #00005277, CI# 2659-000016-22 and Intake #00006285, CI# 2659-000017-22 were related to falls with injury.
- Intake: #00008762-E-Correspondance Complainant related to care concerns and bathing.
- Intake: #00013695-2659-000021-22 - Fall with injury.
- Intake: #00014302-IL-07609-LO: Complainant related to alleged neglect and complaint management.
- Intake: #00016605 CI: 2659-000026-22 E-Correspondence Complaint and CIS related to care concerns and call bell system.

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

Infection Prevention and Control
Falls Prevention and Management
Staffing, Training and Care Standards
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Reporting and Complaints
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 37

The licensee has failed to ensure that a specific resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that the resident received a bath twice weekly by the method of their choice.

Review of the resident's electronic care plan in Point Click Care (PCC) noted that the resident was to receive a shower twice a week, as per their preferred method of choice.

Review of the resident's Point of Care (POC) Documentation Survey Report for a specific month, noted the resident received a specific type of bath on a specific date , and a different specific type of bath on another specific date.

In an interview, Personal Support Worker (PSW) stated that if they were not fully staffed, residents were given a bed bath in the morning, as part of the regular morning care.

In an interview, the Director of Care (DOC) viewed the resident's POC Documentation Survey Report with Inspector #733564 and confirmed that the resident did not receive a bath twice weekly by the method of their choice.

Sources:
Review of the resident's care plan, progress notes, and POC Documentation Survey Report; interviews with a PSW, and the DOC.
[733564]

WRITTEN NOTIFICATION: 24/7 RN

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (3)

The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

During an interview with Registered Nurse (RN) #129 they shared that the RN covered the entire building including the Retirement Home. RN #129 stated that the amount of times they were required to attend the Retirement Home was variable but would average one to two times every two weeks.

During an interview with RN #130 they shared that they would be called to attend the Retirement Home on average once weekly but there were times when it could be up to three times per shift.

Review of the homes Job Description Charge RN, policy #500-11-41A, last updated November, 2020, stated "Is responsible for the Nursing and Rest Home on, evenings, nights and weekends and other times delegated by DOC/NM."

Sources: Interview with RN #129 and #130 and review of the Charge RN Job Description.

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WRITTEN NOTIFICATION: Reporting and Complaints Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The home received a written email complaint related to care concerns on a specific date.

On a subsequent specific date the Director of Care (DOC) received an email, requesting a discussion related to additional care concerns.

This Inspector was unable to locate the complaints in the home's complaint tracking binder.

During an interview with the DOC, they stated that they had not received the original email until seven days after it was received, when they returned from vacation. The DOC acknowledged that the two emailed complaints were alleging neglect. The DOC stated that they did not report to the Director and did not include the complaints in the home's complaint binder as they were resolved within 24 hours of receipt.

Sources: Complaint emails, complaint tracking binder and interview with the DOC.

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WRITTEN NOTIFICATION: Failure to report

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home received a written email complaint related to care concerns on a specific date.

On a subsequent specific date the Director of Care (DOC) received an email, requesting a discussion related to additional care concerns.

This Inspector was unable to locate any Critical Incident System reports related to the complainant's allegations of neglect.

The Director of Care (DOC) acknowledged that the two emailed complaint emails were alleging neglect. The DOC stated that they did not report did not submit a Critical Incident Report as they could not substantiate that any neglect had occurred.

Sources: Complaint emails, Critical Incident System and interview with the DOC.
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WRITTEN NOTIFICATION: Care Plan

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

A) The licensee has failed ensure that two specific residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

The home submitted a Critical Incident System report that stated that on a specific date, the staff were

alerted by the resident's medical device that the resident had experienced an incident.

Review of the resident's progress note, stated that on a specific date, the staff were alerted by the resident's medical device that the resident had experienced and incident.

Review of the resident's care plan showed that the medical device intervention was entered into the care plan on the date of the incident, after the incident had occurred.

During an interview with a Registered Practical Nurse (RPN) they stated that the resident had the medical device in place as a prevention intervention prior to the incident.

During an interview with the Director of Care (DOC) they acknowledged that they had entered the medical device into the care plan on the date of the incident after the incident had occurred. The DOC was unable to state when the medical device was initiated however did acknowledge that the medical device had been in place for an extended period of time prior to the incident.

Sources: CIS, the resident's progress notes and care plan and interviews with an RPN and the DOC.

B) Review of a resident's plan of care stated that the resident would perform a specific task independently and required the assistance of a medical equipment and one to two staff for another specific task.

During an interview with a Personal Support Worker (PSW) they shared that the resident's care needs and abilities had changed in the previous two months and the resident was now dependent on staff for care needs. The PSW acknowledged the care plan had not been updated to reflect the residents current care needs.

During an interview with a Registered Practical Nurse (RPN) they shared that the resident's overall condition had changed and that they required additional supports. The RPN acknowledged that the plan of care had not been updated to reflect the resident's change in condition.

Sources: the Resident's clinical record, interviews with an RPN and a PSW.
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WRITTEN NOTIFICATION: Management of Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: The response provided to a person who made a complaint shall include, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

A review of two email complaints related to care concerns, sent to the home on separate dates was completed.

This Inspector was unable to locate a response for either complaint that included Ministry contact information or Patient Ombudsman contact information.

During an interview with the Director of Care (DOC) they stated that the complaints were resolved within 24 hours of receiving them so the Ministry and patient Ombudsman information was not provided.

Sources: The home's investigation files and interview with the DOC.
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WRITTEN NOTIFICATION: Management of Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (3) (a)

The licensee has failed to shall ensure that the documented record is reviewed and analyzed for trends at least quarterly.

A review of two email complaints related to care concerns, sent to the home on separate dates was completed.

This Inspector was unable to locate the two complaints in the complaint binder in the home.

During an interview with the Director of Care (DOC) they confirmed that the emails were written complaints alleging neglect. The DOC stated that the complaints would not be part of the quarterly analysis as they felt they were resolved within twenty four hours.

Sources: Complaint emails, review of the complaint binder and interview with the DOC.
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COMPLIANCE ORDER CO #001 Communication and Response System

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 20 (g)

The inspector is ordering the licensee to comply with a Compliance Order:
Specifically:
-The licensee shall physically disable the silence function of the remind button and the receiver on the nurse call base at each nurses desk in the home.

Grounds
The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is properly calibrated so that the level of sound is audible to staff.

During an interview with a resident they shared that staff were turning off call bells at the desk and ignoring the bells. The resident expressed that they felt this practice was unsafe for themselves and other residents.

This Inspector attended all five units in the home and found that each unit had a nurse call station at each nurse's station. The call bells rang in both the hallways and at the nurse's desk and the nurses desk alarm could be silenced for one minute by pushing a remind button or lifting the receiver on the alarm base at the desk.

During a tour of the facility with the Administrator they acknowledged that when the alarm was silenced at the nurse's desk, they were unable to hear any bells at the nurse's desk on the Michigan unit and very difficult to hear on the Ontario unit.

During an interview with a Registered Practical Nurse (RPN) they shared that the bells can be silenced at the desk but continue to ring in the hallways. The RPN acknowledged that if there was an activity happening near the desk that the bells could be difficult to hear if silenced at the desk.

During an interview with a Personal Support Worker (PSW) they shared that the staff of the home use the silence function if they are charting or during report.

Sources: Physical testing of the nurse call system and interviews with a resident, the Administrator, an RPN and a PSW.

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This order must be complied with by February 4, 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.