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

Original Public Report

Report Issue Date: April 5, 2023

Inspection Number: 2023-1165-0005

Inspection Type:
Follow up
Critical Incident System

Licensee: Vision '74 Inc.

Long Term Care Home and City: Vision Nursing Home, Sarnia

Lead Inspector	**Inspector Digital Signature**
Kristen Murray (731)	Digitally signed by Kristen Murray Date: 2023.04.19 13:16:18 -04'00'

Additional Inspector(s)
Andrea Dickinson (740895)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 8, 9, 13, 14, 2023
The inspection occurred offsite on the following date(s): March 10, 2023

The following intake(s) were inspected:
Related to falls management:

- Intake: #00018363 - 2659-000002-23
- Intake: #00018718 - 2659-000003-23
- Intake: #00019708 - 2659-000004-23

Related to improper care:

- Intake: #00021308 - 2659-000006-23

Follow Up:

- Intake: #00021331 - Follow-up #: 1 - O.Reg. 246/22 - s. 20 (g)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1165-0003 related to O. Reg. 246/22, s. 20 (g) inspected by Andrea Dickinson (740895)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

A) The licensee failed to ensure that the provision of care set out in the plan of care for a resident's skin and wound treatments was documented.

Rationale and Summary
A resident had a fall that resulted in an injury and an area of altered skin integrity.

During an interview, a Personal Support Worker (PSW) stated that the registered staff were completing treatments for the resident's area of altered skin integrity. The PSW stated they were not sure how often the registered staff provided treatment, but that it seemed like almost every other day. Review of resident's Point Click Care (PCC) chart showed there was no documentation completed regarding the treatments that were completed.

Sources: A resident's PCC chart; interview with a PSW.
[740895]

B) The licensee has failed to ensure that the provision of care set out in a resident's plan of care, related to their Personal Assistive Safety Device (PASD), was documented.

Rationale and Summary
A resident's plan of care stated a PASD was required for safety and staff were to remove, reposition and reapply the PASD every two hours. There was no documentation showing that staff had removed, repositioned, and reapplied the PASD every two hours. The resident's care records identified that they were to have safety checks completed every hour. Documentation was not completed for safety checks on six instances.

In an interview, a Personal Support Worker (PSW) stated the resident's PASD was to be checked, removed, and repositioned every two hours and documented in Point of Care (POC). The Director of Care (DOC) confirmed there was no documentation for removing and repositioning the resident's PASD in POC. The DOC confirmed that documentation for safety checks should have been completed.

There was risk the resident may not have had their PASD checked and repositioned without the documentation to support the completion of care.

Sources: Clinical records for a resident, including plan of care, documentation survey report and task records; and interviews with a PSW and the DOC.
[731]

C) The licensee failed to ensure that the provision of care set out in the plan of care for a resident's safety checks were documented.

Rationale and Summary
A resident was identified to require safety checks completed every hour. As part of the resident's fall prevention interventions, the resident had a falls intervention which required hourly safety checks be completed. The resident was observed with the fall prevention intervention in place.

Review of the resident's Documentation Survey Report from PointClickCare (PCC) for three months, showed there was no documentation completed for the safety checks on 17 instances.

During an interview, the Director of Care (DOC) confirmed there should not be blanks in the documentation for safety checks and stated if it is not documented than it cannot be proven that it was completed.

The resident required hourly safety checks related to their falls risk and intervention. There was

increased risk to the resident related to the hourly safety checks not being completed when the staff did not document the care for the resident.

Sources: A resident's PCC chart, and interview with the DOC.
[740895]

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that a resident was bathed, at minimum, twice per week.

Rationale and Summary
A resident's plan of care identified they were to receive baths twice each week. The resident did not receive a bath during a week in February.

In an interview, a Personal Support Worker (PSW) stated residents should receive baths twice per week and they are documented in Point of Care (POC) or in the progress notes. The Director of Care (DOC) confirmed that the resident should have received two baths during the week and the documentation indicated they did not.

The resident not receiving a minimum of two baths a week could potentially impact their quality of life.

Sources: Clinical records for a resident, including plan of care, documentation survey report and task records; and interviews with a PSW and the DOC.
[731]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident, who was exhibiting areas of altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
A resident had two areas of altered skin integrity. A review of the resident's clinical records indicated that there were no initial assessments completed for either area of altered skin integrity using a clinically appropriate assessment instrument.

During an interview, a Registered Nurse (RN) confirmed that the resident had been identified as having two skin impairments. The RN confirmed there were no initial skin assessments completed for the resident's areas of altered skin integrity.

Review of policy 550-W-25, titled "Wounds, Assessments and Monitoring of," original date dated January 10, 2001, last revised November 2020, stated "When a resident is discovered to have an alteration in skin integrity, the RPN assesses the area using the Wound Flow Sheet in PCC."

During an interview, the Director of Care (DOC) stated that there were no Wound Flow Sheets completed for the resident's areas of altered skin integrity and there should have been. The DOC confirmed that the resident's wounds were not assessed using a clinically appropriate assessment instrument.

There was increased risk to the resident when the home did not complete an assessment of the resident's skin impairments using a clinically appropriate assessment instrument upon their return from hospital.

Sources: A resident's PCC chart; policy 550-W-25, titled "Wounds, Assessments and Monitoring of," original date dated January 10, 2001, last revised November 2020; interviews with a RN and the DOC. [740895]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

The licensee failed to ensure a resident who was exhibiting areas of altered skin integrity, was assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Rationale and Summary
A resident had two areas of altered skin integrity. Review of the resident's assessment in Point Click

Care (PCC) identified there were no dietary referrals for either area of altered skin integrity.

Number seven under the procedure section of policy 550-W-25, titled "Wounds, Assessments and Monitoring of," dated January 10, 2001, last revised November 2020, stated "The RPN is required to complete a Nutrition Referral (PCC Assessments) to alert the Dietitian of the presence of a wound (I-X) and to request wound healing interventions."

During an interview with the Registered Dietitian (RD), they stated they had not received any referrals for the resident in relation to the skin impairments. When asked if they had completed an assessment for the resident upon becoming aware of the area of altered skin integrity, the RD stated they had just recently become aware, and it was not completed, but would be on their list. When asked if they would have made any changes to the resident's plan of care if they had been aware of their skin impairments, the RD stated that depending on the resident's intake status at the time, they may have added a protein or a nutritional supplement.

The Director of Care (DOC) confirmed that a referral was not completed related to the resident's skin impairments. The DOC confirmed a referral would normally be made for the types of skin impairments the resident had and stated a referral should have been sent to the Dietitian.

There was increased risk to the resident when a referral to the Dietitian was not made regarding the resident's skin impairments, as the Dietitian may have implemented additional nutritional supplements to promote healing.

Sources: A resident's PCC chart; policy 550-W-25, titled "Wounds, Assessments and Monitoring of," dated January 10, 2001, last revised November 2020; interviews with the RD and the DOC.
[740895]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure that a resident who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Rationale and Summary
A resident had an area of altered skin integrity. Review of the resident's orders in Point Click Care (PCC)

showed there were no skin and wound treatments or daily monitoring in place for the resident's area of altered skin integrity. Review of the resident's PCC assessments tab showed there were no weekly wound assessments completed for their area of altered skin integrity.

Review of policy 550-W-25, titled "Wounds, Assessments and Monitoring of," dated January 10, 2001, last revised November 2020, stated the following under the procedure section:
"5. Once treatment is determined a monitoring schedule is placed in the E-TAR and Wound Flow Sheet (PCC) intervals are set.
Stage 1: Nursing Measure is put in place in the TAR to monitor daily and apply dressing if applicable and a weekly full wound assessment will be completed.
6. The RPN shall document with each assessment or check of the wound using a Skin Integrity PN type."

During an interview, a Registered Nurse (RN) confirmed there were no weekly wound assessments completed for the resident's area of altered skin integrity. When asked if the expectation would be for the area to be assessed weekly, the RN stated that they should be or at least charted saying that the area had healed. The Director of Care (DOC) stated that the wound should have been monitored weekly with an associated Wound Flow Sheet assessment in PCC.

There was increased risk to the resident of poor skin healing when the home did not complete weekly wound assessments to monitor the status of the wound. At the time of inspection, staff stated that the resident had no active skin impairments.

Sources: A resident's PCC chart; policy 550-W-25, titled "Wounds, Assessments and Monitoring of," dated January 10, 2001, last revised November 2020; interviews with a RN and the DOC.
[740895]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 2.

The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 35 of the Act: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

Rationale and Summary

A resident's paper chart identified an order written by the nurse practitioner for a restraint as needed. During observations on three days, the resident was noted to have the restraint intervention in place.

A PSW stated during an interview that the resident used the restraint intervention constantly. When asked during an interview how often the resident used the restraint, an RPN stated it was used anytime that the resident was in their mobility device. The RPN stated the restraint was applied for safety as a falls prevention intervention.

The Director of Care (DOC) stated they were not aware that the staff utilized the resident's restraint upon waking each morning and that the restraint should be reassessed with family consent for the resident to use the restraint at all times, and the order changed.

The resident required the use of a restraint as needed for fall prevention. There was increased risk to the resident when the staff did not apply the device in accordance with the nurse practitioner's order.

Sources: A resident's paper chart; resident observations; interviews with a PSW, a RPN and the DOC. [740895]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.

The licensee failed to ensure that the following requirements were met where a resident is being restrained by a physical device under section 35 of the Act: That the resident was released from the physical device and repositioned at least once every two hours.

Rationale and Summary
A resident had a restraint assessment indicating the use of a restraint as well as an associated order from the nurse practitioner for the restraint as needed. The resident's care plan showed the restraint as a fall intervention. It was not part of the resident's care plan to release the restraint and reposition the resident every two hours, and there were no Point of Care (POC) tasks that required documentation by the Personal Support Workers (PSWs) caring for the resident upon review of the Documentation Survey Report V2 in Point Click Care (PCC).

During interviews, staff were not aware that they had any specific requirements to release and

reposition the resident from their restraint. When asked during an interview if there was any point that they had to release the restraint, a PSW stated no and that it would only be released when continence care was provided. An RPN stated that the resident's restraint would be released, and the resident repositioned during their continence care.

Review of the home's policy 550-R-10A titled "Restraints," dated April 1989 and last revised January 2023, stated under number five, subsection b of the procedure section "The Registered staff must delegate to the PSW/HCA to document on the Point of Care Resident Record as required to indicate: The PSW/HCA must indicate on a minimum of Q 2 hours that the resident has been released and repositioned."

The Director of Care (DOC) confirmed that the release and repositioning of the resident was required per the home's restraints processes. The DOC confirmed that the expectation would be that every release of the device and repositioning be documented and stated that it should be under the POC tasks. The DOC confirmed that every release and repositioning related to the use of the restraint was not documented for the resident.

The resident was required to be released from the restraint and repositioned at least every two hours. There was increased risk to the resident when staff were not aware of the specific requirements related to the restraint to release and reposition the resident every two hours and document.

Sources: A resident's PCC and paper chart; policy 550-R-10A titled "Restraints," dated April 1989 and last revised January 2023; interviews with a PSW, a RPN and the DOC.
[740895]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 6.

The licensee failed to ensure that the following requirements were met where a resident is being restrained by a physical device under section 35 of the Act: 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.

Rationale and Summary
A resident received an order from the nurse practitioner for a restraint as needed (PRN). The resident had a change in health status. Review of the resident's restraint order showed that the first and second checks of order were completed and entered into the electronic Medication Administration Record (eMAR) for registered staff members to sign two times a day.

Number four of the procedure section of the home's policy 550-R-10A, titled "Restraints," issued April 1989 and last revised January 2023, stated "Once the Physician /RNEC order is received, the consent and restraint assessment is completed; the Registered Staff must document in the EMAR every 8 hours to evaluate the restraint need, resident observations and behaviour, resident condition and the need to continue."

The Director of Care (DOC) stated that restraint order should be reassessed by a physician or nurse practitioner upon a resident's change in health status. Review of the resident's paper chart showed that the restraint order was not included on the resident's change in health status and there were no other subsequent orders related to the resident's restraint. The DOC confirmed that the order was not reassessed with the physician or nurse practitioner and should have been.

When asked if the resident's condition would be reassessed and the effectiveness of the restraint evaluated by a physician, RN in the extended class (RNEC), or registered staff member at least every 8 hours, the DOC confirmed it should be and that it would be documented in the eMAR. Upon the DOC's review of the resident's eMAR, they stated that the order just stated restraint as needed (PRN) but should state to assess the restraint every eight hours and that staff would sign off on it. The DOC confirmed that per the current restraint PRN order in the eMAR registered staff were signing two times per day, which did not meet the requirement to be reassessed every eight hours.

Review of the resident's assessment tab in Point Click Care (PCC), showed a Restraint Use Assessment V2 – V2, which indicated that the resident utilized a restraint as the resident was at risk of falls. There were no restraint assessments noted at the time the order for the restraint, or upon the resident's change in condition. The DOC stated that the PCC restraint assessment should have been done upon the resident's change in condition, in order to re-evaluate what the resident needed, and had not been completed.

There was increased risk to the resident when the order was not re-evaluated when their condition changed. There was also increased risk to the resident when the PCC restraint assessment was not completed every 8 hours.

Sources: A resident's PCC and paper chart; policy 550-R-10A, titled "Restraints," issued April 1989 and

last revised January 2023; interview with the DOC.
[740895]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 5.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee failed to ensure that the person who applied the device and the time of application was documented.

Rationale and Summary
During observations on three shifts, a resident was noted to have a restraint in use. During an interview with a Personal Support Worker (PSW), they stated the resident used the restraint constantly. The PSW stated that the restraint was applied when they got the resident up that morning. When asked if they had to document anywhere that the restraint was on, the PSW stated that it would be in their charting about the resident wearing a restraint.

During an interview with a Registered Practical Nurse (RPN), they stated that the resident's restraint was used anytime the resident was in their mobility device and that the restraint had been applied that morning when the resident got up from bed. When asked if the application of the restraint was documented anywhere, the RPN stated that it should be and that the PSWs would document in their Point of Care (POC) charting. The RPN stated that they did not have to document the application and the reason for its application anywhere.

The Point Click Care (PCC) Documentation Survey Report V2 for the resident, showed there were no interventions or tasks specific to restraints for the PSWs to document on. Review of the resident's orders showed that registered staff are required to sign the restraint PRN order twice daily. During an interview, the DOC confirmed that there was no supporting documentation for the resident's restraint in the POC tasks assigned to the PSWs. When asked if it was documented who applied the device and the time of application on the dates the resident was observed wearing the restraint, the DOC stated that it was just signed in the eMAR, but that it did not state the time the restraint was put on. The DOC stated all of that information should be in a progress note in the resident's chart. Review of the resident's progress notes showed there was no additional documentation from the registered staff regarding the application of the restraint.

Sources: A resident's PCC chart; observations; interviews with a PSW, RPN and the DOC. [740895]

WRITTEN NOTIFICATION: Medication Management System

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that written policies and protocols developed for the medication management system regarding the administration of drugs were implemented for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a medication management system and it was complied with.

Specifically, staff did not comply with the policy "Drug Administration: Controlled Substances", last revised May, 2022, which was included in the licensee's medication management program.

Rationale and Summary
Review of a resident's Point Click Care (PCC) progress notes showed that the resident had a fall, and had experienced pain. The resident's paper chart showed that a Registered Nurse (RN) received an order from the nurse practitioner for pain medication. A progress note from that evening stated that the resident had been given the medication.

Review of the resident's electronic Medication Administration Record (eMAR) showed that the pain medication had not been entered, and there was therefore no documentation of the medication's administration recorded in the eMAR.

Review of Policy 3.3 from Silver Fox Pharmacy titled "eMAR Order Processing," last revision May 2022, stated that it is the responsibility of the nursing staff to input orders into the eMAR.

Review of Policy 8.1 from Silver Fox Pharmacy titled "Drug Administration: Controlled Substances," last revision May 2022, under the administration section it stated to "verify the medication that is to be administered for accuracy against the [e]MAR" and to "Document on [e]MAR immediately after the medication is administered before moving on to the next resident"

During an interview, the RN confirmed upon their review of the resident's eMAR that there was no

documentation of the pain medication. The RN stated they had called the nurse practitioner for an order but didn't recall administering the medication and believed that the Registered Practical Nurse (RPN) had given it. The RN stated that they probably told the RPN they would put the order in and that they must have forgotten. The RN confirmed the expectation would be that when an order is received it is entered into the eMAR and stated they did not put the order in the eMAR when they were supposed to.

During an interview, the Registered Practical Nurse (RPN) confirmed they had administered the pain medication to the resident after their fall. When asked where the administered medication was documented, the RPN stated the medication would have been documented in the eMAR. The RPN reviewed the eMAR with the Inspector and confirmed that the pain medication was not documented and signed for in the eMAR. The RPN confirmed the expectation would be that when an order is received it is entered into the eMAR and signed when it is administered.

There was low risk to the resident when the medication administration was not documented in the eMAR as the resident received the medication at the time of the order.

Sources: A resident's PCC and paper chart; Silver Fox Pharmacy policies; and interviews with a RPN and RN.
[740895]