Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2014	2014_261522_0006	L-000151-14	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

JULIE LAMPMAN (522), ALISON FALKINGHAM (518), PATRICIA VENTURA (517)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 5, 6, 7, 10, 11, 12, 13, 17, 2014

A Concurrent Complaint Inspection was conducted by Inspector #517 and #518 under L-000209-14

During the course of the inspection, the inspector(s) spoke with The Assistant Administrator, Director of Care, Nurse Manager, Maintenance Manager, Food Services Manager, 4 Registered Nurses, 10 Registered Practical Nurses, a Recreation Facilitator, 2 Health Care Aides, 14 Personal Support Workers, 3 Dietary Aides, 5 Family Members and approximately 40 Residents

During the course of the inspection, the inspector(s) During the course of the inspection, the inspector(s) toured all resident home areas,
medication rooms, observed dining service, medication pass, provision of resident care,
recreational activities, resident/staff interactions, infection prevention and control practices,
reviewed residents' clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 failed to ensure the Readmission From Hospital Policy was complied

with in respect to Registered Nursing Staff completing a Return from Hospital Checklist which includes an Admission Nursing Physical Assessment, Pain Assessment, Skin Assessment and Falls Risk Assessment upon a residents' return from hospital.

Review of the home's policy number 500-111-120 Re-Admission From Hospital states that
Residents returning from a hospital admission will be considered as Re-Admitted. The RN/RPN on the unit is required to complete the following items and note completion in a Return from Hospital Checklist form: Admission Nursing Physical Assessment and Vital Signs, Skin Assessment, Pain Assessment and Falls Risk Assessment.

Review of Resident #968's clinical record revealed that a Return From Hospital Checklist form, an Admission Nursing Physical Assessment and a Pain Assessment were not completed upon the resident's return from hospital.

Review of Resident #944's clinical record revealed that a Return From Hospital Checklist, Admission Nursing Physical Assessment, Pain Assessment, Falls Risk Assessment and Skin Assessment were not completed upon the resident's return from hospital.

This was confirmed by the Registered Nurse and the Nurse Manager.

The Nurse Manager confirmed that her expectation would be that the Return from Hospital Checklist form, an Admission Nursing Physical Assessment, Pain Assessment, Skin Assessment and Falls Risk Assessment be completed upon a resident's return from hospital.

The licensee failed to ensure that the home's Readmission From Hospital Policy was complied with. [s. 8. (1)]

2. The licensee failed to ensure that the home's Falls Management and Reduction Program and Falls Prevention Program was complied with in respect to Registered Nursing staff initiating a Post Fall Head Injury Routine for all unwitnessed resident falls, completing a Post Fall Huddle Quick Minute Tool and ensuring that a fall tile logo is placed at the head of a resident's bed.

The Falls Management and Reduction Program policy number 550-F-02A states that

when a resident falls the following process is initiated:
1)Initiate Head Injury Routine (HIR) for un-witnessed falls where there is a potential for head injury and witnessed falls that have resulted in a potential head injury.
2) Gather any staff on the unit at the time of the fall for de-briefing of the falls using a quick minute form as part of your investigation, ideally before the end of the shift.

A review of resident #944's clinical record revealed:

A Post Fall Huddle Quick Minute note was not completed for a fall on a specified date.
A Head Injury Routine and Post Fall Huddle Quick Minute note was not completed for a fall on a specified date.
A Head Injury Routine was documented however the form was not dated for a fall on a specified date.

The Falls Prevention Program Policy Number 550-F-01B states a resident fall risk logo is placed in each resident room based on low, medium or high risk at the time of admission. The logo is changed by registered staff when the resident's fall risk changes.

An observation of resident #944's room revealed that the resident did not have a fall tile logo above the bed. This was confirmed by the Registered Practical Nurse.

Interview with the Nurse Manager confirmed the expectation that a fall tile should be placed at each resident's bedside upon admission and reviewed after each fall. The Nurse Manager also confirmed the expectation that a Post Fall Head Injury Routine should be initiated for all unwitnessed resident falls and that a Post Fall Huddle Quick Minute Tool should be completed after each resident fall.

The licensee failed to ensure the home's Falls Management and Reduction Program and Falls Prevention Program was complied with in respect to post fall assessment and management. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the home's Pain Management Program was complied.

Review of the home's Pain Management Program Policy number 500-VII-250A states when pain is observed or reported to be persistent or unresolved or the severity of pain worsens, a further pain assessment must be conducted, results documented and

further reported to the physician.

A review of resident #944's clinical record revealed that a recent pain assessment had not been completed.

Interview with the Nurse Manager confirmed the expectation that a pain assessment is completed when a resident is experiencing pain.

The licensee failed to ensure that the home's Pain Management Program was complied with in respect to completing a pain assessment when a resident is experiencing pain. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee failed to ensure the home's Food Temperature Check policy was complied with in respect to Dietary Aides taking food temperatures prior to each meal service.

Review of the home's Dietary policy number 200-IV-110 Food Temperature Checks states the Dietary staff person completes form 200-204 recording the temperature of both hot and cold foods prior to meal service.

A review of temperature checks revealed there were no temperatures taken for breakfast, dinner and for the gravy served with the lunch entree on specified dates.

Interview with the Dietary Aide confirmed that the temperatures were not taken.

Interview with the Food Services Manager confirmed the expectation that food temperatures should be taken prior to each meal service.

The licensee failed to ensure the home's Food Temperature Check policy was complied with in respect to taking food temperatures prior to each meal service. [s. 8. (1) (b)]

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition of the resident requires, a post fall assessment is conducted using a clinically appropriate assessment instrument.

Review of the home's Falls Management and Reduction Program policy number 550-F-02A revealed that fall risks are reviewed quarterly and that a fall risk assessment should be completed upon any return from hospital.

On separate occasions Resident #939 had a fall and was assessed at the hospital.

A review of the resident's clinical record revealed that a post falls assessment was not completed after each fall.

The Registered Practical Nurse confirmed that the fall risk assessment tool was not completed for each of the resident's falls or as part of the resident's quarterly assessment.

Interview with a Registered Practical Nurse and Health Care Aide confirmed that the resident is a high risk for falls.

Observation of the resident's room revealed that a high risk fall tile was not placed above the resident's bed.

The Registered Practical Nurse confirmed that a high risk fall tile should have been placed over the resident's bed.

The licensee failed to ensure that when resident #939 fell, the resident was assessed and that a post fall assessment was conducted. [s. 49. (2)]

2. Review of Resident #944's clinical record revealed that a post fall assessment had not been completed.

This was confirmed by the Registered Practical Nurse and Nurse Manager.

The Nurse Manager confirmed the expectation that a post fall assessment is completed after every resident fall.

The licensee failed to ensure that when resident #944 fell, the resident was assessed and that a post fall assessment was conducted. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that a post fall assessment is completed when a resident has fallen, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is 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 are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered staff upon any return of the resident from hospital.

Review of the home's Skin Assessment Head to Toe policy number 550-S-22 states that additional mandatory head to toe assessments are conducted following a hospital stay.
Review of the home's Return from Hospital Policy 500-111-120 states that upon return from hospital a skin assessment, fall risk assessment and pain assessment must be completed.

Review of Resident #939's clinical record revealed that there were no documented skin changes in the resident's MDS and no skin assessment had been completed after specific falls.

Interview with the Registered Nurse revealed that wound assessments are conducted weekly and documented in the resident's TAR. Mandatory head to toe assessments are conducted following a hospital stay. For residents who are not admitted or in hospital for 24 hours a specific skin assessment tool is not used.

Interview with the Registered Nurse Wound Care Lead confirmed that the assessments were not completed and the expectation would be that a skin assessment would be completed when a resident returns from hospital.

The licensee failed to ensure that resident #939 received a skin assessment upon return from hospital [s. 50. (2) (a) (ii)]

2. A review of Resident #944's clinical record revealed a Skin Assessment was not completed upon the resident's return from hospital.

Review of the home's Re-Admission From Hospital policy number 500-111-120 states that Residents returning from a hospital admission will be considered as Re-Admitted. The RN/RPN on the unit is required to complete the following items and note completion in a Return from Hospital Checklist form: Admission Nursing Physical Assessment and Vital Signs, Skin Assessment, Pain Assessment and Fall Risk Assessment.

The Registered Practical Nurse (RPN) confirmed that a skin assessment should have been completed upon the resident's return from hospital.

Interview with the Nurse Manager confirmed that there was no documentation of a skin and wound assessment for the resident upon return from hospital and that it is the home's expectation that a skin and wound assessment be completed upon return from hospital.

The licensee failed to ensure that resident #944 received a skin assessment upon return from hospital [s. 50. (2) (a) (ii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for a skin and wound

assessment.

Review of the home's Skin, Wound and Pressure Ulcer Prevention Program policy number 500-S-23-24A revealed that a Complete Skin Assessment Tool must be completed on return from hospital and quarterly.

Review of resident #939's clinical record revealed that the resident had not received a recent quarterly skin assessment.

The Registered Practical Nurse confirmed that a quarterly skin assessment had not been completed on the resident and a weekly wound assessment had not been completed for the resident's altered skin integrity.

Interview with the Registered Nurse Wound Care Lead confirmed the expectation that a wound assessment should be conducted weekly for all wounds and that quarterly skin assessments should be completed on all residents.

The licensee failed to ensure that resident #939 received a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents receive a quarterly skin assessment, that resident's with altered skin integrity receive a weekly skin assessment and resident's receive a skin assessment upon return from hospital, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee 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 has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complainant alleges harm or risk of harm to one or more residents, that the investigation commenced immediately.

An interview with a Family Member revealed the Family Member made a verbal complaint to the Assistant Administrator. The Family Member reported to the inspector that no follow-up was conducted in response to the concern.

The Assistant Administrator (AA) confirmed that a verbal complaint was received from the Family Member. The AA confirmed that she did not follow-up with the complainant regarding this complaint.

The licensee failed to ensure that a response was provided to the complainant within 10 business days of receipt of the complaint regarding resident care. [s. 101. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that a response is provided to a complainant within 10 business days of receipt of a complaint regarding the care of a resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection control program.

Inspector #522 observed a shared resident bathroom. The observation revealed two tubes of toothpaste that were unlabelled and stored on the same shelf in the resident's bathroom.

Interview with Personal Support Worker/Housekeeper confirmed that all toothpaste should be labelled and verified that the toothpaste in the resident's shared bathroom was not labelled for either resident.

During a tour of the home Inspector #518 observed that staff were not washing their hands between residents and housekeeping staff were not washing their hands between rooms. The inspector observed a used glove on the floor outside a resident room.

Inspector #518 observed droplet precaution signage for a shared resident room and noted that the isolation kit was missing for that same room.

The inspector observed a contact precautions isolation kit on the door of a resident room although there was no contact precaution signage posted. Interview with the Infection Control Nurse confirmed that the signage was missing and that signage should be posted on the door of the resident room.

Inspector #518 observed an isolation kit set up outside a resident room. There was no signage posted on the door of the resident room. Interview with the Registered Nurse and the Infection Control Nurse confirmed there should be signage posted outside the resident room.

The licensee failed to ensure that all staff participate in the implementation of the infection control program. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all staff participate in the implementation of the infection control program, to be implemented voluntarily.

WN #6: 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 failed to ensure that there was a written plan of care for resident #939 that sets out clear direction to staff and others who provide direct care to the resident.

Record review revealed no documentation on the resident's care plan related to skin care.

Further record review revealed no skin and wound care interventions in the resident's care plan.

Interview with the Registered Nurse Wound Care Lead confirmed that skin and wound care and any interventions should have been documented on the care plan.

The licensee failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) 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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. 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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to report to the director the alleged abuse of resident #932.

The home completed an internal investigation but failed to report the abuse to the Ministry of Health and Long Term Care (MOHLTC).

The Assistant Administrator confirmed she did not report the alleged abuse to the MOHLTC.

The licensee failed to report the alleged abuse of a resident to the Director. [s. 24. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to report to the police the alleged abuse of resident #932.

The home completed an internal investigation but failed to report the alleged abuse to the police.

The Assistant Administrator confirmed she did not report the alleged abuse to the police.

The licensee failed to report to the police the alleged abuse of a resident. [s. 98.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 140. Every licensee of a long-term care home shall ensure that each medical absence, psychiatric absence, casual absence and vacation absence of a resident of the home is recorded. O. Reg. 79/10, s. 140.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #968's medical absence was recorded.

Review of the resident's MDS Assessments did not reflect that the resident was discharged to hospital with a return anticipated nor did it reflect that the resident returned from hospital.

Registered Nursing staff and the Nurse Manager confirmed that the information was missing from MDS.

Interview with the Nurse Manager confirmed her expectation that a MDS Assessment be completed to reflect the resident's hospitalization.

The licensee failed to ensure that each medical absence of a resident of the home is documented. [s. 140.]

Issued on this 30th day of April, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522), ALISON FALKINGHAM (518), PATRICIA VENTURA (517)
Inspection No. / No de l'inspection :	2014_261522_0006
Log No. / Registre no:	L-000151-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 29, 2014
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 :	HEATHER MARTIN

To VISION '74 INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

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 prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 8(1) to ensure the home's policies and procedures are complied with.
The plan must ensure how education will be provided to staff related to the policies and procedures and how compliance will be monitored.

Please submit the plan in writing to Julie Lampman, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON, N6A 5R2, by email, at julie.lampman@ontario.ca, by May 16, 2014.

Grounds / Motifs :

1. The Re-Admission From Hospital Policy number 500-111-120 was not complied with when resident #944 returned from hospital and the following assessments were not completed:
a Return from Hospital Checklist form which includes an Admission Nursing Physical Assessment and Vital Signs, Skin Assessment, Pain Assessment and Fall Risk Assessment.
The Nurse Manager confirmed her expectation that the Re-Admission From Hospital Policy number 500-111-120 is complied with when a resident returns from hospital. (522)

2. The Pain Management Program Policy number 500-VII-250A was not

complied with when a pain assessment was not completed on Resident #944 who was experiencing pain.
The Nurse Manager confirmed the expectation that the Pain Management Program Policy number 500-VII-250A is complied with for a resident who was experiencing pain. (522)

3. The Falls Management and Reduction Program Policy number 550-F-02A was not complied with when resident #944 fell and the following information was not completed as part of the post falls assessment:
A Post Fall Huddle Quick Minute Note was not documented for a specific fall.
A Head Injury Routine and Post Fall Huddle Quick Minute Note was not completed for a specific fall.
A Head Injury Routine was documented however the form was not dated for a specific fall.

The Falls Prevention Program Policy number 550-F-01B was not complied with when the resident had several falls and a fall logo tile was not placed at the resident's bedside.

The Nurse Manager confirmed the expectation that the Falls Prevention Program Policy number 550-F-01B and the Falls Management and Reduction Program Policy number 550-F-02A is complied with after a resident fall.

(522)

4. The Re-Admission From Hospital Policy number 500-111-120 was not complied with when resident #968 returned from hospital and the following assessments were not completed:
a Return from Hospital Checklist form which includes an Admission Nursing Physical Assessment and Vital Signs, Skin Assessment, Pain Assessment and Falls Risk Assessment.
The Nurse Manager confirmed her expectation that the Re-Admission From Hospital Policy number 500-111-120 is complied with when a resident returns from hospital. (522)

5. A review of the Food Temperature Checks Policy number 200-IV-110 revealed that
the Dietary staff are to record the temperatures of both hot and cold foods prior to meal service.
This policy was not complied with when temperature checks were not taken for dinner, breakfast and for the gravy served with the lunch entree on specified days.
The Food Services Manager confirmed the expectation that the Food Temperature Checks Policy number 200-IV-110 is complied with and that hot and cold food temperatures are to be taken at every meal. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
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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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Julie Lampman

Name of Inspector / Nom de l'inspecteur : Julie Lampman

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