Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
September 29, 2010	2010_107_2890_29Sep095611 2010_146_2890_27Sep135804	Complaint H-01127

Licensee/Titulaire
Bella Senior Care Residences Inc.,
1000 Finch Avenue West, Suite 901, Toronto ON, M3J 2V5
416-667-0957 Fax

Long-Term Care Home/Foyer de soins de longue durée
Bella Senior Care Residence
8720 Willoughby Drive, Niagara Falls ON, L2G 7X3

Name of Inspector(s)/Nom de l'inspecteur(s)
Michelle Warrener - #107
Barb Naykalyk-Hunt - #146

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to food production and resident care.

During the course of the inspection, the inspectors spoke with: The Director of Care, Food Services Manager, Environmental Manager, Cooks, Dietary staff, Nursing staff, and Residents.

During the course of the inspection, the inspectors: Reviewed production systems, meal preparation, observed meal service and sampled meal items, reviewed menus, Food Committee and Resident's Council meeting minutes, and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Food Quality

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[4] WN
[1] VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6(7)
6(7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

1. At the lunch meal September 29, 2010, two identified residents received the incorrect texture of menu item. The residents have a physician order for a pureed menu, however, they were provided a minced texture side dish (minced cucumbers) instead of the planned pureed vegetable (pureed zucchini), creating a risk for choking. The appropriate side dish was prepared and available at the meal, however, was not served to the residents.
2. An identified resident has a plan of care that requires honey consistency thickened fluids, however the consistency of thickened water provided to the resident was more than pudding thick. The Inspector turned the cup (with a spoon inside the cup) upside down and the fluid did not move. The resident did not consume the thickened water.

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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 with ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 129(1)(a)(ii)
129(1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked.

Findings:

1. At 5:45 p.m. September 29, 2010, the medication cart, on a unit where residents with cognitive impairment reside, was left unlocked and unattended with medications sitting on-top of the cart.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 72(2)(d) 72(2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu (g) documentation on the production sheet of any menu substitutions.
Findings: 1. The menu stated pureed watermelon, however, pureed pineapple was prepared and served to residents. 2. The menu requires pureed marinated green beans for the lunch meal September 30, 2010, however, pureed peas were prepared. Pureed peas with mushrooms were also planned for the supper meal September 30, 2010, resulting in reduced variety of items being served to residents as a result of the substitution which was not marked on the production sheet.. 3. Pureed pineapple was substituted for pureed watermelon, however, this was not documented on the production sheet for the lunch meal September 29, 2010.

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WN #4: The Licensee has failed to comply with O. Reg. 79/10, s. 72(4)(c) 72(4) The licensee shall maintain, and keep for at least one year, a record of, (c) menu substitutions.
Findings: 1. A record of menu substitutions for the previous two months was not available. The records had been discarded and were unavailable for review by the Inspector.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** M Wanner
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). October 15, 2010