Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 23, 2015 | 2015_342611_0002 | H-002231-15, H-001568-14 | Critical Incident System |

### Licensee/Titulaire de permis

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST SUITE 901 TORONTO ON M3J 2V5

### Long-Term Care Home/Foyer de soins de longue durée

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KELLY CHUCKRY (611)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): May 7, 12, and 14, 2015**

**Inspector #146 was also in attendance during this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), registered staff, Personal Care Providers (PCP's) or Personal Support Workers (PSW's) and residents. Information was gathered during this inspection through on-site clinical record review, interviews with residents and staff, as well as observations.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 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 has failed to ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provided direct care to the resident. 2007, c. 8, s. 6 (1

A) Resident #007's current written plan of care directed staff, under the focus of behaviours, to check the resident every fifteen (15) minutes for safety and document. The same written plan of care, under the focus of high risk for falls, directs staff to check resident every one (1) hour to ensure safety. The directions given to staff as to how often to check the resident were conflicting and unclear. This information was confirmed by the DOC.

B) Resident #007's current written plan of care directed staff, under the focus of mood, to encourage resident to attend group activities. A progress note entry on May 12, 2015 indicated that resident #007 was not permitted to attend recreational activities if only one recreational staff member was present. Three out of three staff members interviewed indicated that resident #007 was not able to attend recreational activities if only one recreational staff member was present, as they would not be able to monitor for responsive behaviours. The directions provided to staff with respect to participation in group recreational activities in the plan of care were conflicting. This information was confirmed by the DOC. [s. 6. (1) (c)]

***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 to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with. 2007, c. 8, s. 20 (1).

The home has a policy in place, 4.1.2 Abuse and Neglect Prevention, as part of their Abuse and Neglect Prevention Program. The identified policy defines sexual abuse as (i) any consensual or non-consensual touching, behaviour or remarks or a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (ii) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. The policy also indicated "the Administrator/designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System or via pager (after hours or holidays) upon becoming informed of an alleged act of abuse". In addition the policy indicated "the Administrator/designate shall notify the POA/SDM within 12 hours of becoming aware of any other alleged, suspected, or witnessed incident of abuse or neglect of a resident". This policy was not complied with on the following occasions:

A) On December [redacted] 2014 it was documented in the resident's progress notes by registered staff that resident #001 was exhibiting responsive behaviours towards resident #005 during two separate incidences. These incidences were in the form of sexually inappropriate behaviour and were not reported to The Ministry of Health and Long Term Care by the Administrator/designate. This was confirmed by the Administrator and DOC.

B) On December [redacted] 2014 it was documented that resident #001 was exhibiting responsive behaviours towards resident #006. This incident was in the form of sexually inappropriate behaviour and was not immediately reported to The Ministry of Health and Long Term Care by the Administrator/designate. This was confirmed by the Administrator and DOC.

C) On January [redacted] 2015 it was documented that resident #001 was exhibiting responsive behaviours towards resident #003. This incident was documented as sexually inappropriate behaviour and was not immediately reported to The Ministry of Health and Long Term Care. This was confirmed by the Administrator and DOC.

D) Resident # 001 exhibited responsive behaviours towards resident #005 on December [redacted] 2014, towards resident #006 on December [redacted] 2014 and towards resident #003 on January [redacted] 2015. The home failed to notify the POA/SDM for resident #005, #006 and #003. This was confirmed by the Administrator and DOC.

E) On March 22, 2015 resident #007 exhibited responsive behaviours towards resident #010.
This incident was not reported to The Ministry of Health and Long Term Care immediately via the Critical Incident Reporting System or via an after hours telephone report. This incident was initially identified by the home as abuse. This was confirmed by the Administrator and DOC.

F) On March 31, 2015 resident #007 exhibited responsive behaviours towards resident #009.
This incident was not reported to The Ministry of Health and Long Term Care immediately via the Critical Incident Reporting System or via an after hours telephone report. This incident was initially identified by the home as abuse. This was confirmed by the Administrator and DOC.

G) On May 3, 2015 resident #007 exhibited responsive behaviours towards resident #010. This incident was not reported to The Ministry of Health and Long Term Care immediately via the Critical Incident Reporting System or via an after hours telephone report. This incident was initially identified by the home as abuse. This was confirmed by the Administrator and DOC.

H) On May 8, 2015 resident #007 exhibited responsive behaviours towards resident #011. This incident was not reported to The Ministry of Health and Long Term Care immediately via the Critical Incident Reporting System or via an after hours telephone report. This incident was initially identified by the home as abuse. This was confirmed by the Administrator and DOC. [s. 20. (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 to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy is complied with. 2007, c. 8, s. 20 (1)., to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. O. Reg. 79/10, s. 30 (2).

A) On December [redacted] 2014 resident #001 exhibited responsive behaviours towards resident # 005. The home failed to document this incident and resident #005's response to the incident in the clinical record of resident #005

B) On December [redacted] 2014 resident #001 exhibited responsive behaviours towards resident #006. The home failed to document this incident and resident #006's response to the incident in the clinical record of resident #006.

C) On January [redacted] 2015 resident #001 exhibited responsive behaviours towards resident #003. The home failed to document this incident and resident #003's response to the incident in the clinical record of resident #003.

The Administrator, DOC and ADOC confirmed that this information was not documented in the respective residents clinical records and that residents responses were not documented. [s. 30. (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 to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the training related to mental health issues, including care for persons with dementia, included training in techniques and approaches related to responsive behaviours. s. 76 (7)

A) A review of the homes 2014 and 2015 responsive behaviour education indicated that 64 out of 105 direct care staff did not receive training related to mental health issues related to techniques and approaches to responsive behaviours. The DOC and ADOC confirmed this education was not completed. [s. 221. (3)]

***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 to ensure that the training related to mental health issues, including care for persons with dementia, includes training in techniques and approaches related to responsive behaviours, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,**
**(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).**
**(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).**
**(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's programs and services, specifically with the Responsive Behaviour Program and the protocol for the referral of residents to specialized resources were co-ordinated and implemented on an interdisciplinary basis.

A) Resident #001 exhibited a total of six (6) incidences of responsive behaviours toward other residents on October 24, 2014, December [redacted] 2014, December [redacted] 2014, March 27, 2015 and April 7, 2015. During this time period the home did not complete a referral to available specialized resources. The homes Responsive Behaviour Program or "Behavioural Support Program" The DOC confirmed that these referrals were not completed for resident #001. [s. 53. (2) (a)]

and Supt 9115

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**Issued on this 21st day of July, 2015**

[redacted]

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

**Original report signed by the inspector.**

This report has been amended for the purpose of publication [redacted] 9/11/15