



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

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

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

**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
Direction de l'amélioration de la
performance et de la conformité**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 28, 2015	2015_323130_0005	H-001619-14	Complaint

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

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

**This inspection was conducted on the following date(s): January 28, February 16,
March 26, 27, 2015**

**Please note: this complaint inspection was partially conducted during the Resident
Quality Inspection (RQI) on January 28, 2015.**

**During the course of the inspection, the inspector(s) spoke with the Administrator,
Director of Care (DOC), Assistant Director of Care (ADOC), Registered staff,
personal support workers (PSWs), and the identified resident's Power of Attorney
(POA).**

**The following Inspection Protocols were used during this inspection:
Personal Support Services**

During the course of this inspection, Non-Compliances were issued.

5 WN(s)

0 VPC(s)

2 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :



1. The licensee failed to protect resident #500 from neglect by the licensee or staff.

A) On an identified date in 2014, the home reported a critical incident which occurred on an identified date in 2014. The report indicated that resident #500 fell during a transfer.

On a later date in 2014, it was confirmed in hospital that the resident had sustained injuries. A diagnostic imaging report dated shortly after the incident date in 2014 also confirmed injury.

The home's investigation revealed that the two PSWs involved in the transfer admitted they had not used safe lift and transfer technique.

The two identified PSWs confirmed during interviews with the Inspector that they had not used safe lift and transfer technique.

Staff's neglect to follow safe lift and transfer technique on an identified date in 2014, resulted in harm to the resident. [s. 19. (1)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that safe transferring and positioning devices or techniques were used when assisting resident #500.

A) On an identified date in 2014, the resident was transferred from bed to their chair. Staff reported that during the transfer, the resident fell to the floor; resulting in minor injuries; however, it was confirmed that the resident sustained multiple injuries as a result of the fall. On an identified date in 2015, the two identified PSWs confirmed during interviews with the Inspector that the resident did not fall to the floor as originally reported. The staff verified they failed to use proper lift and transfer technique during the transfer and as a result the resident fell and sustained injuries.

Staff did not use safe transferring techniques when transferring the resident. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

**WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :



1. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A) Resident #500 returned from hospital on an identified date in 2014, with a treatment order in place. The treatment remained in place until it was discontinued later in 2014. During this time period the written plan of care did not identify the need for the treatment, the need for monitoring or risks associated with its use. Staff verified the plan of care was not updated when the resident's care needs had changed. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee did not report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

A) On an identified date in 2014, the home reported a critical incident report indicating that on an identified date in 2014, resident #500 fell during a transfer by two PSWs, which resulted in injury. The home's internal investigation concluded that the two PSWs neglected to use safe lift and transfer technique. This action resulted in serious harm to the resident. The DOC confirmed the home did not amend the original critical incident report and that this new information was never communicated to the Director. [s. 23. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



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Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :



1. The licensee failed to comply with the following:

A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).

On an identified date in 2014, the home reported a critical incident report, with a category description of an "incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's condition".

The incident report indicated that on an identified date in 2014, two PSWs were transferring resident #500 from bed to their chair, which resulted in a fall with injury. The report indicated upon initial assessment that the resident sustained minor injuries.

On a later date in 2014, the resident was transferred to the hospital for assessment, where injuries were confirmed. A diagnostic imaging report dated later in 2014, confirmed additional injury.

On an identified date in 2015, the two PSWs involved in the transfer verified they failed to use safe lift and transfer techniques. The staff confirmed the resident did not fall, as originally reported. Both PSWs verified they did not initially report that they did not use safe lift and transfer technique while transferring the resident.

Investigation notes reviewed and statements made by the DOC confirmed that on an identified date in 2014, she became aware of the facts surrounding the incident; however, the critical incident report was not amended to include the facts surrounding the incident. [s. 107. (4) 1.]



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Issued on this 28th day of August, 2015

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

Original report signed by the inspector.



**Ministry of Health and
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**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

**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**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : GILLIAN TRACEY (130)

Inspection No. /

No de l'inspection : 2015_323130_0005

Log No. /

Registre no: H-001619-14

Type of Inspection /

Genre

Complaint

d'inspection:

Report Date(s) /

Date(s) du Rapport : Jul 28, 2015

Licensee /

Titulaire de permis : BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST, SUITE 901, TORONTO,
ON, M3J-2V5

LTC Home /

Foyer de SLD : BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : BRENDA HARKER

To BELLA SENIOR CARE RESIDENCES 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are not neglected by the licensee or staff, specifically when using transfer equipment such as a mechanical lifts.

Grounds / Motifs :



**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

**Ministère de la Santé et
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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

1. Previously issued as VPC on May 21, 2013 and CO on September 6, 2013.

The licensee failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

A) On an identified date in 2014, the home reported a critical incident which occurred on an identified date in 2014. The report indicated that resident #500 fell during a transfer.

On a later date in 2014, it was confirmed in hospital that the resident had sustained injuries. A diagnostic imaging report dated shortly after the incident date in 2014 also confirmed injury.

The home's investigation revealed that the two PSWs involved in the transfer admitted they had not used safe lift and transfer technique.

The two identified PSWs confirmed during interviews with the Inspector that they had not used safe lift and transfer technique.

Staff's neglect to follow safe lift and transfer technique on an identified date in 2014, resulted in harm to the resident. [s. 19. (1)] (130)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2015



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

**Ministère de la Santé et
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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

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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 : 002

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensure staff use safe transferring and positioning devices or techniques when assisting residents, specifically with the use of mechanical lifts.

The plan shall be submitted via email to Gillian.Tracey@ontario.ca on or before June 15, 2015.

The plan shall include the following:

- a) Education for all relevant staff in the use of mechanical lifts and related policies.
- b) Quality monitoring activities to ensure compliance.

Grounds / Motifs :



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Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee failed to ensure that safe transferring and positioning devices or techniques were used when assisting residents.

A) On an identified date in 2014, the resident was transferred from bed to their chair. Staff reported that during the transfer, the resident fell to the floor; resulting in minor injuries; however, it was confirmed that the resident sustained multiple injuries as a result of the fall. On an identified date in 2015, the two identified PSWs confirmed during interviews with the Inspector that the resident did not fall to the floor as originally reported. The staff verified they failed to use proper lift and transfer technique during the transfer and as a result the resident fell and sustained injuries.

Staff did not use safe transferring techniques when transferring the resident. [s. 36.] (130)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 14, 2015



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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



**Ministry of Health and
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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
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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.



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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, 11^e 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.



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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 28th day of July, 2015

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : GILLIAN TRACEY

Service Area Office /

Bureau régional de services : Hamilton Service Area Office