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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 15, 2016	2016_247508_0010	007377-16	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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

Please Note: Complaint inspection log #016257-16 was conducted concurrently with this inspection.

This inspection was conducted on the following date(s): June 10, 14, 2016

During the course of this inspection, the inspector toured the facility, interviewed staff, residents and family, observed dining service, reviewed resident clinical records, complaint log and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered staff, Personal Support Workers (PSW), residents and family.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Responsive Behaviours

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

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 LTCHA, 2007, s. 20. Policy to promote zero tolerance

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

It was witnessed by a staff member on an identified date in 2015, that resident #004 touched resident #001 inappropriately in the hallway. The staff person intervened and re-directed resident #004 away from resident #001. Resident #001 was witnessed saying to resident #004 that they did not like being touched.

The home's abuse policy #4.1.2, titled Abuse and Neglect Prevention, indicated that the Administrator/designate shall notify the POA/SDM (Power of Attorney/Substitute Decision Maker) within 12 hours of becoming aware of any alleged, suspected, or witnessed incident of abuse or neglect of a resident.

A review of the clinical record for resident #001 indicated that registered staff attempted to contact the POA/SDM after this incident to inform them of what had occurred; however, they were not able to reach the SDM and could not leave a message.

The POA/SDM had appointed a second contact person in the event that the home was not able to reach the SDM. This information was provided to the home and documented in the resident's clinical record. There were no attempts to contact this person when they could not contact the POA/SDM.

It was confirmed by registered staff and by the clinical documentation on June 10, 2016, that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20.]

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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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 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.

Resident #001 required a specific treatment, when necessary (PRN), due to multiple health conditions.

On an identified date in 2016, it was observed by staff that the resident was experiencing symptoms of the resident's diagnosis and staff applied the resident's treatment as ordered. The Registered Practical Nurse (RPN) on duty assessed the resident and indicated during an interview that she also provided support to the resident. The RPN indicated that the resident's symptoms subsided.

Later that night, the Registered Nurse (RN) on duty assessed the resident and had indicated to the RPN the following morning during report that the resident only required their treatment once during the night.

The next morning the RPN went into assess resident #001 after receiving report as the resident was again exhibiting symptoms. The RPN stated during an interview that the resident's treatment was applied, however, the resident was still exhibiting symptoms. The RPN called the RN on duty from the resident's room for further assessment and to prepare a transfer of the resident to hospital. The resident expired during this time.

A review of the clinical record indicated that the assessments by the RPN and the assessment conducted by the RN had not been documented. The treatment that was administered to the resident had not been signed for by registered staff.

It was confirmed by review of the resident's clinical record and through interviews conducted with the Director of Care on June 14, 2016, and with the RPN on June 15, 2016, that not all actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

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Issued on this 15th day of July, 2016

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

Original report signed by the inspector.