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
Oct 5, 2016	2016_248214_0019	011894-16, 013067-16, 013293-16, 013302-16, 018992-16, 019360-16, 019671-16, 019967-16, 022147-16, 023712-16, 024195-16, 024588-16, 025386-16, 025804-16	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

CATHY FEDIASH (214), GILLIAN TRACEY (130)

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): August 24, 25, 26, 29, 30, 31, September 1, 6, 7, 8, 13, 14, 15, 19, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, registered staff, physiotherapy staff, personal care providers (PCPs), Social Services Worker, dietary staff, residents and families. During the course of this inspection the inspector reviewed Critical Incident System (CIS) submissions; reviewed the home's investigative notes; reviewed resident health records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 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.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).

s. 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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A review of a Critical Incident System (CIS) submitted by the home indicated that on an identified date in 2016, resident #120 had demonstrated an identified alteration to their skin to a specified area on their lower limb. The cause of the alteration was unknown. Mobile diagnostic testing indicated a possible injury. The resident was transferred to hospital where diagnostic testing confirmed an identified injury. The resident returned to the home from hospital on the same day with a treatment device in place.

A review of the resident's physician's orders indicated that on an identified date in 2016, orders for a change in transfer were received that included if the resident was wearing their treatment device, they were to be transferred with two staff assistance standing pivot transfer and if the resident refused their treatment device, they were to be transferred with a mechanical lift and two staff.

A review of the resident's written plan of care indicated under the transfer focus that if the resident refused to wear their treatment device, they were to be transferred with a mechanical lift and two staff and if the resident was wearing their treatment device, they were to be transferred with two staff assistance standing pivot transfer; however, the locomotion/mobility and the pain focus indicated that the resident was non weight bearing.

An interview with the RAI Coordinator and the DOC confirmed that the resident's written

plan of care in relation to their weight bearing needs had not set out clear directions to staff and others who provided direct care.

This non-compliance was issued as a result of the following CIS inspection #011894-16. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) A review of a CIS submitted by the home indicated that on an identified date in 2016, resident #120 had demonstrated an identified alteration to their skin to a specified area on their lower limb. The cause of the alteration was unknown. Mobile diagnostic testing indicated a possible injury. The resident was transferred to hospital where diagnostic testing confirmed an identified injury. The resident returned to the home from hospital on the same day with a treatment device in place.

A review of the documentation in the resident's clinical record indicated that on the date of the identified alteration to their skin, the resident had complaints of discomfort and pain. A review of the resident's Electronic Medication Administration Record (EMAR) indicated that the resident had been prescribed an analgesic to be taken twice daily. A review of the EMAR on this date indicated that the second daily dose was documented with a chart code of "9", indicating to see Nurses Notes. A review of the resident's progress notes indicated that the analgesic was not available. An interview with registered staff #297 confirmed that resident #120 had not received their analgesic as ordered.

A review of the resident's written plan of care indicated under the pain focus dated with an identified date of revision, that staff were to administer pain medication as ordered. An interview with the DOC on an identified date confirmed that the care was not provided to the resident as specified in their plan.

This non-compliance was issued as a result of the following CIS inspection #011894-16.

B) A review of a CIS that was submitted by the home on an identified date indicated the home was investigating an allegation of staff abuse/neglect towards resident #124 who had verbalized on an identified date that they had not received proper care during an evening shift.

A review of the resident's written plan of care in place at the time of the alleged incident indicated that the resident was to have two staff provide extensive assistance for their dressing, transferring, toileting and hygiene needs.

The home's amended CIS and investigative notes confirmed that staff #074 had provided assistance by them self to resident #124 for their dressing, transferring, toileting and hygiene needs on the identified date.

An interview with registered staff #274 and the DOC confirmed that care had not been provided to the resident as specified in their plan.

This non-compliance was issued as a result of the following CIS inspection #024195-16. (Inspector #214) [s. 6. (7)]

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

WN #2: 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 ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On an identified date, observations reported by staff #059 indicated that resident #114 was attempting to self- propel their mobility device into their room. Registered staff #283 was heard yelling at the resident and holding onto an identified area of the resident's body to prevent them from entering. The resident was resisting the registered staff's action and continued to make attempts to enter their room but was forcibly prevented by the registered staff. The resident was interviewed and confirmed they were upset by the incident. The Director of Care confirmed the action taken by registered staff #283 constituted abuse.

This non-compliance was issued as a result of the following CIS inspection #025386-16. (Inspector #130). [s. 19. (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 all residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: 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 failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's Abuse and Neglect Prevention Policy 4.1.2., revised June 2015, was reviewed and indicated the following:

i) The Director of Care and Registered Staff shall ensure that the immediate needs of the resident are attended to, including but not limited to:
- ensuring the residents safety immediately and on an ongoing basis.
- emotional support.
- arrangements for ongoing emotional and physical support and care.
- the Attending Physician shall be notified immediately of all suspected/actual physical, or sexual abuse and the physician shall conduct a medical assessment of the resident.
- the Registered Nursing Staff/Director of Care shall document a detailed description of the incident in the resident's record. The documentation is to be outline a description of the incident and physical findings and the care and treatment provided. An investigation shall be commenced immediately.

ii) Under "Investigation process for resident abuse by formal caregiver": abuse or neglect of residents will not be tolerated. The Administrator/Designated shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System or via pager (after hours or holidays).

iii) The Registered Nursing Staff/Director of Care shall document a detailed description of the incident in the resident's record. The documentation is to outline a description of the incident and physical findings and the care and treatment provided.

iv) An investigation shall be commenced immediately. While the investigation is being conducted: a) The suspected/accused staff member shall be relieved of their duties with pay.

A) On an identified date an allegation of staff to resident abuse was witnessed and immediately reported by staff #059 to Nurse Manager #266. The Nurse Manager confirmed that resident #114 was not assessed following the incident nor was the incident documented or the physician called. The DOC confirmed the incident was not immediately investigated until they became aware of the allegation of abuse, the following day.

The home's Abuse and Neglect Prevention Policy was not complied with.

This non-compliance was issued as a result of the following CIS inspection #025386-16. (Inspector #130).

B) A review of a CIS that was submitted by the home on an identified date indicated the home was investigating an allegation of staff abuse/neglect towards resident #124. A review of the home's investigative notes and an interview with registered staff #274, indicated that the resident had verbalized they had not received proper bedtime care on an identified date. Registered staff #274 confirmed that the home became aware of the allegation the following day.

Registered staff #274 confirmed that the home had not reported this allegation to the Ministry of Health and Long Term Care (MOHLTC) for five days after becoming aware of the allegation as the home wanted to speak with the suspected staff member first and that staff #274 was not present in the home during one of the days between becoming aware of the allegation and the date of reporting to the MOHLTC.

A review of resident #124's clinical record indicated that no documentation containing a detailed description of the alleged incident had been recorded in the resident's record. An interview with registered staff #274 confirmed that no documentation had been recorded.

An interview with registered staff #274 and the DOC as well as a review of the suspected staff member's weekly time sheets confirmed that the suspected staff member had not been relieved of their duties until five days after the home became aware and had worked two full shifts in between the time of the home becoming aware and the suspected staff member being relieved of their duties.

Registered staff #274 and the DOC confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents had not been complied with.

This non-compliance was issued as a result of the following CIS inspection #024195-16. (Inspector #214). [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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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,
(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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of a CIS submitted by the home indicated that on an identified date in 2016, resident #120 had demonstrated an identified alteration to their skin to a specified area on their lower limb. The cause of the alteration was unknown. Mobile diagnostic testing indicated a possible injury. The resident was transferred to hospital where diagnostic testing confirmed an identified injury. The resident returned to the home from hospital on the same day with a treatment device in place.

A review of the resident's progress notes indicated that 14 days prior, the resident was identified as having an alteration to their skin to a specified area on their lower limb. The progress note indicated that the alteration to the resident's skin integrity was of an unknown origin. A review of the resident's clinical records indicated that a reassessment of the resident's altered skin integrity was conducted four days later and that the skin alteration remained. No further weekly reassessments of the residents altered skin integrity were conducted for ten days. An interview with registered staff #307 confirmed that they were not aware of the resident's skin alteration that had been identified initially on a specified date. An interview with the DOC confirmed that the resident was not reassessed at least weekly by a member of the registered nursing staff.

This non-compliance was issued as a result of the following CIS inspection #011894-16. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: 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 that any plan, policy protocol, procedure, strategy or system was complied with.

A review of the home's policy titled, "Concerns, Issues and Complaints (4.2.10 with a review date of March 2016) indicated the following under procedure:

Every written or verbal complaint made to a staff member concerning the care of a resident or operation of the home is dealt with as follows:

i) Any staff member who receives a question, concern or complaint shall obtain the Suggestions, Concerns and Complaint Form and provide the form to the resident, family member, visitor, or volunteer with the form.
ii) The staff member will assist the resident, family member, visitor or volunteer with completing the form.
iii) The form is forwarded to the Department Manager/Supervisor.
iv) A written response must be provided to the person making the complaint within 10 business days of the receipt of the complaint.

A review of a CIS that was submitted by the home on an identified date as well as the home's investigative notes indicated that resident #124 had verbalized a complaint of not receiving proper care on a specified date.

A review of the home's Complaint's Log Binder as well as an interview with registered staff #274 confirmed that the Suggestions, Concerns and Complaint Form had not been initiated when the resident verbalized concerns regarding the care they received. Registered staff #274 confirmed that the home had not complied with their policy.

This non-compliance was issued as a result of the following CIS inspection #024195-16. [s. 8. (1) (b)]

WN #6: 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.

A review of a CIS submitted by the home indicated that on an identified date in 2016, it was identified that resident #120 had demonstrated an identified alteration to their skin to a specified area on their lower limb. The cause of the alteration was unknown. Mobile diagnostic testing indicated a possible injury. The resident was transferred to hospital where diagnostic testing confirmed an identified injury. The resident returned to the home from hospital on the same day with a treatment device in place.

A review of the resident's progress notes on two identified dates in 2016, indicated that the resident verbalized pain and discomfort to the specified area on their lower limb. A review of the resident's EMAR indicated that the resident had been prescribed an analgesic to be taken every four hours when needed (prn). A review of the resident's EMAR as well as progress notes for the two identified dates, indicated that no analgesics had been offered or administered. An interview with registered staff #299 and #307 indicated that the resident had been offered the prn analgesic on both identified dates; however, the resident refused on both occasions and the staff confirmed that no documentation regarding actions taken with respect to pain interventions had been documented in the resident's progress notes or the EMAR.

This non-compliance was issued as a result of the following CIS inspection #011894-16. [s. 30. (2)]

WN #7: 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 had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of a CIS that was completed by the home indicated that on an identified date in 2016, resident #125 sustained a fall resulting in a specified injury.

A review of the resident's clinical record indicated that a post fall assessment had not been completed when they sustained this fall with injury.

The DOC confirmed that a post fall assessment had not been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

This non-compliance was issued as a result of the following CIS inspection #018992-16. (Inspector #214) [s. 49. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents annual retraining in accordance with O. Reg. 79/10, s. 219(1) in the area of Pain management, including pain recognition of specific and non-specific signs of pain in accordance with O. Reg. 79/10, s. 221(1)4 in relation to the following: [76(7) 6]

An interview with the Director of Care indicated that during a specified time in 2016, the home was no longer using an online learning management system that was previously used to provide education and training to staff. The Director of Care confirmed that the home was unable to provide documentation that the 129 staff who provided direct care to residents received retraining in the area of pain management in 2015 as the home was unable to retrieve the training records from the previously used online learning system and were unable to locate these records in the home.

This non-compliance was issued as a result of the following CIS inspection #011894-16. [s. 76. (7) 6.]

Issued on this 20th day of October, 2016

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

Original report signed by the inspector.