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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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
Mar 7, 2017	2017_569508_0001	026631-16, 027147-16, 027302-16, 029228-16, 035042-16	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.

This inspection was conducted on the following date(s): January 10, 12, 16, 17, 18, 19, 20, 2017.

During this inspection the Inspector toured the facility, observed provision of resident care, observed meal services, reviewed video footage, reviewed resident clinical records, staff training records, medication incident reports and relevant policies and procedures. This inspection was conducted concurrently with follow up inspections, log #004624-17 related to responsive behaviours and log #004616-17, related to safe lift and transfers, Critical Incident (CI) inspections, log #001568-17, #001524-17, #001570-17, related to reporting certain matters to the Director.

During the course of the inspection, the inspector(s) spoke with the interim Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI Co-ordinator), the Nursing Unit Clerk, the Nursing Consultant, registered staff, Personal Care Providers (PCP), agency staff, residents and family.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Medication
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were bathed at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During a review of the clinical records for residents #001, #002 and #003, it was identified that these residents were not consistently being bathed twice a week as per their plan of care.

During an interview with the Resident Assessment Instrument (RAI) Coordinator, the RAI Coordinator indicated that if the baths were offered and the residents refused, this would be documented in the Point of Care (POC) documentation and in the progress notes section of the resident's clinical records.

On identified dates where residents #001, 002, 003 should have been bathed, there was no documentation that the residents were offered and refused their baths. Interviews with family members also confirmed that the residents were not consistently offered two baths per week.

It was confirmed through documentation and during interviews with staff and family members that the residents were not bathed, at a minimum, twice per week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (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 residents are bathed at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

A) A review of the home's Quality Improvement Documentation records titled Medication Incident/Near Incident Adverse Drug Reaction Report, revealed that a report had been completed on an identified date in 2016, when the registered staff had documented that they could not locate a controlled substance. It was later found; however, had been unaccounted for and not reported to the Director.

B) On an identified date in 2016, a medication incident report was completed by the ADOC when it was identified that the RPN documented on an identified date in 2016, that they could not locate a patch on an identified resident when they went to remove it.

C) On an identified date in 2016, a medication incident report was completed by the ADOC when it was identified that the RPN documented on two identified dates in 2016, that they could not locate the patches on an identified resident.

It was confirmed through documentation and during an interview with the Assistant Director of Care (ADOC) on January 16, 2016, that the home did not notify the Director of these incidents as required for the missing or unaccounted for controlled substances. [s. 107. (3) 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 Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance, to be implemented voluntarily.

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. (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 that for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #003 had identified responsive behaviours which included being resistive to care. The resident's written plan of care directed staff to bath the resident at a specified time on two specific days twice per week.

During a review of the most recent resident bathing list, which staff confirmed that they also refer to for directions in providing care to residents, it was identified that the resident's bath days were changed due to the resident's responsive behaviours and preferences.

It was confirmed by the Resident Assessment Instrument (RAI) Co-ordinator on January 16, 2017, that the written plan of care did not set out clear directions to staff and others who provided direct care to the resident. [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.

Resident #001 had a toileting plan of care with specific written instructions on how to toilet the resident. On an identified date in 2017, it was witnessed that the resident was not being toileted as specified in their plan. During an interview with staff #100, it was confirmed that the staff who provided care to resident #001 were not familiar with the resident's care needs.

It was confirmed during an interview with staff #100 and during an interview with a family member that the care set out in the resident's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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Issued on this 28th day of March, 2017

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

Original report signed by the inspector.