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 prévue le Loi de 2007 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

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 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 11, 2017;	2017_587129_0002 (A1)	028384-16, 029382-16, 029657-16, 032091-16, 032191-16, 034289-16, 034757-16, 000910-17, 001158-17, 001376-17, 002773-17, 002983-17	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

LISA VINK (168) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This Inspection Report has been amended, on the request of the long term care home, to provide an extension for compliance dates.

Issued on this 11 day of June 2017 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 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

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 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 11, 2017;	2017_587129_0002 (A1)	028384-16, 029382-16, 029657-16, 032091-16, 032191-16, 034289-16, 034757-16, 000910-17, 001158-17, 001376-17, 002773-17, 002983-17	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

LISA VINK (168) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 9, 10, 13, 14, 15, 16, 22, 23, 24, March 3, 7, 8, 9, 10, 13, 15, 16, 20, 21, 22, 27, 28, 29, 30 and 31, 2017

During this inspection the following Critical Incidents were inspected: Log # 028384-16 related to falls management, #029382-16 related to management of responsive behaviours, #029657-16 related to management of responsive behaviours, #032091-16 related to improper care of a resident, #032191-16 related to management of responsive behaviours, #034289-16 related to prevention of resident abuse, #034757-16 related to prevention of resident neglect, #000910-17 related to management of responsive behaviours, #001158-17 related to falls prevention and management,# 001376-17 related to falls prevention and management ,#002773-17 related to medication administration, #002983-17- related to prevention of resident abuse and #0005202-17 related to resident abuse.

This inspection was conducted concurrently with Complaint Inspection #2017_587129_003 and Follow Up Inspection #2017_587129_00005.

During the course of the inspection, the inspector(s) spoke with Residents, family members, the Licensee, the Administrator, the Nurse Consultant, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nursing Unit Clerk, Resident Assessment Instrument (RAI) Coordinator, and the Admissions and Social Services Coordinator.

During this inspection observations of care provided to residents were made, meal service was observed and the administration of medication was observed.

During the course of this inspection resident clinical records, staff schedules, documentation of audits and program reviews, Licensee policies and procedures, employee files and other documents and records maintained by the home were reviewed.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
22 WN(s)
9 VPC(s)
10 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. 6. Plan of care

Specifically failed to comply with the following:

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).

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 care set out in the plan of care was provided to the resident as specified in the plan.

a) Registered staff did not ensure the care set out in the plan of care was provided to an identified resident as specified in the plan, in relation to the following:
i) The Director of Care (DOC) directed all registered staff to implement a twice daily observation related to a specific treatment and this direction was added to the resident's plan of care. The clinical record contained directions that staff were to observe the specific treatment ordered for the resident and document that they had completed this in a specified part of the resident's plan of care. A review of resident's clinical record indicated that registered staff documented on seven days during an identified month in 2016 and three days during the following month that the resident refused to allow staff to observe the specific treatment. Registered staff #612 confirmed that the resident often refused to let them observe the specific treatment, they did not take any action beyond the first attempt to observe the treatment and there was not an alternate plan in place to ensure the directions to observe the specific treatment were complied with.

ii) The identified resident's plan of care specified that the resident was to have an identified procedure completed daily. On an identified date the resident was observed and the procedure had not been completed. Personal Support Worker (PSW) #611 confirmed that the resident had not had the procedure completed and that the resident would often demonstrate a responsive behaviour when staff

attempted to complete the procedure. Registered staff # 612 confirmed that they had not been informed that the resident had demonstrated responsive behaviours related to this procedure and documentation made by PSWs in the days preceding the above noted date did not indicate that the resident had demonstrated responsive behaviours related to this procedure. On a second identified date the resident was observed and it was noted that the resident had not had the procedure completed. The date following this identified date PSW #178 confirmed that they had not provided the procedure on the preceding day. Staff failed to ensure the resident was provided care related to an identified procedure as directed in the resident's plan of care.

iii) The identified resident's plan of care indicated the resident was at risk for falling. The plan of care specified that staff were to ensure the call bell was accessible to the resident and encourage the resident to call for assistance. On an identified date the resident was observed and it was noted that the call bell was not accessible to the resident. PSW staff #611 confirmed the resident was not able to reach the call bell to call for assistance. Staff failed to ensure that care was provided to the resident as specified in the plan of care.

iv) The identified resident's plan of care included directions for the management of a care device. The plan of care provided three specific directions for staff related to the identified device. On two identified dates the resident was observed and it was noted that the directions identified in the plan of care had not been followed. Staff failed to ensure that care was provided as specified in the plan of care related to the management of a care device.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log # 032191-16)

b) Registered staff did not ensure the care set out in the plan of care was provided to an identified resident as specified in the plan, in relation to the following:
i) The identified resident's plan of care included a care focus which indicated the resident was at risk for falling and care plan interventions were put in place to decrease the number of falls experienced by the resident. At the time of this inspection registered staff #613 confirmed that the interventions identified in the plan of care were not in place. Staff did not ensure that the care specified in the plan of care related to falls management was provided to the resident. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months, when the resident's care

needs change and when the care set out in the plan has not been effective.

a) An identified resident was not reassessed and the plan of care was not reviewed and revised at least every six months related to pain and pain management. Three consecutive quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coding activities completed in 2016 indicated that pain the resident experienced had changed both in relation to intensity and frequency.
Documentation in the clinical record indicated the resident received medication throughout the above noted periods of time.
Registered staff #183 indicated that following RAI-MDS coding activities noted above, if a care area such as pain did not trigger a Resident Assessment Protocol (RAP) document, staff completing the RAI-MDS activity would complete a non-triggered RAP note in the resident's progress notes in order to complete an assessment/reassessment of pain. A review of progress notes confirmed that a clinical note had not been written by staff related to the pain care focus. There was no documentation in the resident's clinical record to indicate a reassessment of the effectiveness of the pain management strategies had been attempted. Registered staff #183 confirmed the effectiveness of the plan of care being provided to the resident to manage pain had not been reassessed over a 10 month period of time in 2016.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log # 032191-16)

b) An identified resident was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed in relation to continence and responsive behaviours.
Staff and clinical documentation confirmed that the resident's plan of care was not reviewed and revised when the resident's care needs related to continence changed. During interviews, RPN #608, PSW staff #603 and PSW staff #604 confirmed that the resident's continence had changed and the resident demonstrated a responsive behaviour. At the time of this inspection, RPN #603 confirmed the resident's plan of care did not indicate a change in continence and there was no indication that the resident demonstrated a responsive behaviour. Minimum Data Set (MDS) data collected during an identified month in 2017, confirmed that the resident continence had changed. Registered staff #608, the Nurse Consultant and the clinical record confirmed that the resident's plan of care had not be reviewed or revised when the resident's continence care needs and patterns changed or when the resident began demonstrating responsive behaviours related to continence.

(PLEASE NOTE: The above noted non-compliance was identified while completing Critical Incident Log #002983-17)

c) An identified resident's plan of care was not reviewed or revised when the care identified to prevent falls was not effective and the resident continued to fall.
The resident's plan of care indicated that the resident was a risk for falling. The goal of care initiated on an identified date in 2014, indicated that this resident would have no further falls during the next quarter. A review of clinical documentation over a five month period of time prior to an identified date in 2016, indicated the resident fell seven times over the five month period of time. Injuries sustained during these falls were documented in the resident's clinical record. At the time of this inspection registered staff #166 confirmed that during the five month period of time identified above the goal of care for this resident related to falls was not reassessed and there were no new care interventions put in place to prevent further falling or minimized the risk of injury from falling for this resident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log # 028384-16)

d) An identified resident's plan of care was not reviewed or revised when the care identified to prevent falls was not effective and the resident continued to fall.
The resident's plan of care indicated that the resident was a risk for falling. The goal of care initiated on an identified date in 2016, indicated that this resident would have no falls. A review of clinical documentation over a five month period of time prior to an identified date in 2017, indicated that the care being provided had not been effective when it was documented that the resident fell seven times over the five month period. Injuries sustained during these falls were documented in the resident's clinical record. At the time of this inspection registered staff #166 confirmed that the resident's plan of care was not reviewed or revised until after the resident had fallen six times.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log # 001158-17)

e) An identified resident was not reassessed and the plan of care was not reviewed or revised when the care being provided related to responsive behaviours was not effective.
Registered staff #168 confirmed that the resident was not reassessed and the resident's plan of care was not reviewed or revised when it was identified that the care being provided to the resident had not been effective in relation to two behavioural goals that had been established for this resident.

i) The resident's plan of care included a goal related to an identified responsive behaviour and interventions put in place to accomplish this goal were initiated and/or revised twice in 2015 and once on an identified date in 2016. Clinical records indicated that incidents of the identified responsive behaviour occurred in 2016, and twice in 2017. Registered staff #168 confirmed that the resident had not been reassess and the care plan was not reviewed or revised when the resident continued to demonstrate the identified responsive behaviour.
ii) The resident's plan of care included a goal related to a second responsive behaviour. Interventions put in place to accomplish this goal were initiated and/or revised in 2016. Clinical records indicated that the resident demonstrated the identified behaviour on an identified date in 2016, 46 times during an identified month in 2017 and 24 times during a second identified month in 2017. Registered staff #168 confirmed that the resident had not been reassess and the care plan had not been reviewed or revised when the resident continued to demonstrate the identified responsive behaviour.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log # 000910-17) [s. 6. (10)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001,002

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 staff complied with the written policy to promote zero tolerance of abuse and neglect of residents.

The licensee's policy "Abuse and Neglect Prevention", identified as subsection 4.1.2 and last revised in June 2015 directed that:
a) Any staff/volunteer witnessing or having knowledge of an alleged/actual abuse or becoming aware of one shall immediately report it to his/her immediate Manager, Director of Care or the Administrator.
Registered staff #170 confirmed that on an identified date in 2017, Personal Support Worker (PSW) #171 reported an incident of staff to resident abuse during which the identified resident received an injury. The resident's clinical record confirmed that the resident had sustained an injury as a result of the noted incident. Registered staff #170 confirmed in a written response to the Director of Care (DOC) that they had not reported this incident to their immediate supervisor, the DOC or the Administrator. Staff failed to comply with this policy when they did not immediately report the above noted allegation of abuse.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log #005202-17)

b) An investigation shall be commenced immediately.

i) Staff did not comply with this direction when they did not immediately investigate an incident that was reported as staff to resident neglect through the submission of a Critical Incident Report (CIR) on an identified date in 2016. At the time of this inspection the home was unable to provide evidence that an investigation had been immediately commenced. Personal Support Worker (PSW) #603 and PSW #604 who were identified as involved in the incident, confirmed that they recalled being

interviewed by the Assistant Director of Care (ADOC), but they were not contacted or interviewed on the day of or the day immediately following the reported incident. Staff failed to comply with this policy when they did not immediately investigate an allegation of neglect.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log #034757-16)

ii) Staff did not comply with this direction when they did not immediately investigate and incident that was identified as staff to resident physical abuse. It was reported to a RPN on an identified date in 2016, that the resident had an injury and that the resident reported the injury had occurred when staff were providing care on an identified date. Clinical documentation indicated that at the time of the incident the resident had described how the injury had occurred. A progress note written in the resident's clinical record as a late entry the day following the incident indicated that the Registered Nurse (RN) and the Director of Care (DOC) were notified of the incident. At the time of this inspection the ADOC and the Nurse Consultant confirmed that they were unable to locate any documentation to confirm that an investigation into this incident was immediately initiated. Staff did not comply with this policy when they did not immediately investigate an allegation of abuse.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log #034289-16)

c) Registered Nursing Staff/Director of Care shall document a detailed description of the incident in the resident's clinical record.

Staff did not comply with this direction when they did not document a detailed description of an incident that occurred on an identified date, which was reported to the Ministry of Health and Long Term Care (MOHLTC) on a Critical Incident Report (CIR). The CIR indicated that the incident was reported as "staff to resident neglect" involving an identified resident. At the time of this inspection a review of the resident's clinical record confirmed that staff had not documented a description of the incident the home had reported to the Ministry.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log #034757-16)

d) Administrator/Designate shall notify the Ministry of Health and Long Term Care (MOHLTC) immediately via the Critical Incident System or via pager (after hours or holidays) of any Abuse/Suspected Abuse/Alleged Abuse.

Staff did not comply with this direction when they did not notify the MOHLTC of a suspected abuse when it was reported on an identified date, that a resident had sustained an injury, as a result of staff action during the provision of care. A progress note written in the resident's clinical record as a late entry the day following the incident, indicated that the Registered Nurse and the Director of Care were notified of the incident. This incident was reported 23 days after the identified incident when the home submitted a CIR to MOHLTC, which indicated that the home was reporting an incident of staff to resident physical abuse.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log #034289-16)

e) Administrator/Designates shall notify the police immediately of any alleged, suspected or witnessed incidents that the home may suspect constitute a criminal offence.

Staff did not comply with this direction when police were not notified of an incident that was reported to the home on an identified date. It was reported to a RPN that an identified resident had sustained an injury that was the result of a PSW providing care to the resident. At the time of the incident the resident was able to explain how the injury had occurred. A progress note written in the resident's clinical record as a late entry the day following the incident, indicated that the Registered Nurse and the Director of Care were notified of the incident. The home submitted a CIR to MOHLTC which indicated they were reporting an incident of staff to resident physical abuse. The ADOC confirmed that at no time were police contacted about this incident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Inspection Log # 034757-16) [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 003

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee failed to implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

Directions for implementation of the licensee's quality improvement and utilization review system were identified in three documents located in the Bella Senior Care Residence Quality and Risk Management Manual. These documents include: "Quality Committee", identified as section 3.0, subsection 3.1 and last reviewed/revised in September 2011; "Quality Process", identified as section 1.0, subsection 1.2 and last reviewed in September 2011 and "Quality Audits", identified as section 5.0, subsection 5.1 and last reviewed in September 11, 2011.

1. The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when

they failed to comply with directions contained in the licensee's policy "Quality Committee".
The preamble of this document set out a structure to be implemented to ensure the governance responsibilities for quality improvement were fulfilled. The structure identified that the governing body (licensee) had the ultimate responsibility for the quality of care and services and the management of risk, the Management Company had delegated responsibility and authority to the Administrator on issues and accomplishments related to quality improvements, the Administrator with the support of the Quality Committee and senior leadership submits quarterly reports to the Manager on quality improvement initiatives and activities for risk management and the responsibility for executing the components of the quality system and procedures are delegated to the Quality Care Teams.
At the time of this inspection the licensee had not ensured that the structure identified in the "Quality Committee" policy had been implemented.

-The Administrator confirmed that support and direction had not been provided to the Quality Care Teams related to the quality improvement process identified in the licensee's policies. The Administrator acknowledged that the Quality Care Teams submitted documentation that indicated they had collected data with respect to identified care areas, but had not analyzed the data, generated solutions or developed improvement plans in accordance with the directions contained in the licensee's policies and procedures. No action had been taken to ensure staff understood and implemented the quality improvement process identified in the licensee's policies and procedures.

-The Administrator confirmed that they had taken no action to monitor the implementation of an improvement plan submitted to the Ministry, in response to a continuous quality improvement compliance order served on the licensee on November 23, 2016. The Administrator indicated that they had not monitored the home's progress towards compliance with the previously issued compliance order because it had not been identified as a priority activity.

- The Administrator confirmed that they had not provided the Management Company with reports related to quality issues or quality improvement accomplishments and they had not reported that the home was not moving towards compliance for a previously issued compliance order related to quality.

-The Licensee confirmed that they may had been copied on some e-mails related to the quality activities in the home, but were not aware of specific initiatives,

focuses or activities to improve the quality of care and services in the home.

2. The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Process".This policy identified a quality improvement process that included: selection and/or modification of indicators, audits or projects; set up routine data collection methods for each critical indicator as a Quality Plan; record the monitoring results and provide some analysis; initiate problem solving activities when variations are flagged and subsequently identified as a pattern or trend in the data; evaluate each indicator to determine the usefulness of the indicator and report the results of monitoring activities in a statistical and descriptive format to staff, teams and the Board.

- Registered staff had been directed to engage in what were identified as quality activities; however, documentation and registered staff completing documentation related to these quality activities confirmed that specific directions related to the quality process identified in the licensee's policy had not been provided and staff identified they were unsure of the reasons for the activities they had been directed to engage in.

- Staff had been provided with as schedule, forms and directions to hold meetings on each resident home area based on identified care areas. A random review of documentation of these meetings for pain, responsive behaviours, skin and wound, restraint reduction and falls care areas confirmed that staff had collected data but had not identified areas for improvement or improvement plans related to the data.

- The Nurse Consultant confirmed that the Director of Care (DOC) and Registered Nurses (RN) were to review care audits being completed on each home area. Documentation provided by the home indicated that registered staff # 182 had forwarded an e-mail communication to the DOC and the Nurse Consultant on January 4, 2017, indicating that they had reviewed 20 audits related to "Responsive Behaviours" and identified nine areas where improvements needed to be made before the home would be in compliance. The Nurse Consultant confirmed that at the time of this inspection there was no documentation to demonstrate that plans had developed or implemented to address the concerns registered staff #182 identified following an analysis of data collected related to the home's compliance with the management of responsive behaviours.

- The plan for corrective action developed by the home and submitted to the Ministry following a compliance order, related to continuous quality improvement, served to the home on November 23, 2016, indicated:
i) Quality Teams were to meet weekly according to the schedule, keep minutes of the meetings, review quality indicators, benchmark (internal), brain storm, problem solve, identify areas for improvement within each program, implement ideas and evaluate the effectiveness of solutions implemented.
ii) The RN on each unit to complete all minutes, track quality indicators and record in the quality module within Point Click Care.
The Nurse Consultant confirmed that the data collected at the meetings noted above had not been analyzed, there was no documentation to substantiate that quality indicators had been identified or tracked and the quality improvement process identified in the licensee's policy had not been followed.

3. The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Audits". This policy indicated that standard and routine audits are conducted to ensure that all systems are effective and processes are efficient. Standard audits are conducted minimally of annually and more frequently as outlined in the Audit Schedule. Standardized audits are conducted by members of the interdisciplinary team. The policy identified a number of Administrative Audits, Nursing Service Audits, Recreation and Leisure Audits, Volunteer Service Audits, Dietary Audits, Environmental Services Audits, Accounting Service Audits, Human Resources Audits, Pharmacy Service and Medication Administration Audits and Focused Audits that were to be completed monthly, quarterly, every six months and/or annually.

-The Nurse Consultant confirmed that a Pharmacy Services Audit had not been completed for the 2016 calendar year as was directed in policy, despite the licensee retaining a new Pharmacy Service provider.

-The Nurse Consultant indicated that the annual review of the Medication Management System would be documented in the Professional Advisory Meeting minutes. A review of the Professional Advisory Meeting minutes confirmed that a review of the Medication Management system in the home had not been completed for the 2016 calendar year.

-The Nurse Consultant confirmed that there was no documentation to indicate that

the home had completed an annual review of the Nursing and Personal Support Services staffing plan.

-Documentation indicated that data was collected related to the Falls Management Program on December 28, 2016. The documentation indicated that six areas of the review were responded to negatively and five recommendations were made for improvement. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the recommendations made following the data collected on December 28, 2016.

-Documentation indicated that data was collected related to the Abuse and Neglect Prevention Program during an undated meeting attended by 11 staff. The documentation indicated that 13 areas of the review were responded to negatively. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when recommendations for change had not been made and plans were not developed or implemented based on the negative indicator data collected during this review.

- Documentation indicated that data was collected related to the Restraint Reduction Program on December 28, 2016. The documentation indicated that six areas of the review were responded to negatively. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when recommendations for change had not been made and plans had not been developed or implemented based on the negative indicator data collected on December 28, 2016.

- Documentation indicated that data was collected related to the Pain Management Program on December 31, 2016. The documentation indicated that seven areas of the review were responded to negatively and five recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the negative indicators and recommendations to improve quality were made on December 31, 2016, during this review.

- Documentation indicated that data was collected related to the Behavioural Support Program on December 31, 2016. The documentation indicated that 10 areas of the review were responded to negatively and two recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the negative indicators and recommendations to improve quality made on December 31, 2016, during this review.

- Documentation indicated that data was collected related to the Skin and Wound Program on December 31, 2016. The documentation indicated that 10 areas of the review were responded to as negatively and three recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures were not complied with when plans were not developed or implemented based on the negative indicators and recommendations to improve quality made on December 31, 2016, during this review.

- Documentation indicated that data was collected related to the Continence Care Program on January 3, 2017. The documentation indicated that nine areas of the review were responded to negatively and seven recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the negative indicators and recommendations to improve quality made on January 3, 2017, during this review.

-Seven of the seven annual program reviews identified above were not completed with an interdisciplinary focus as directed in the licensee's policy, two of the above noted annual program reviews were completed by one person and three of the above noted annual program reviews were signed by the Administrator. [s. 84.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the license was subject.
The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment, and any significant change in resident's condition, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.
For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the VB2.
b) RAPs must be generated and reviewed and RAP assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the ARD.

The licensee did not comply with the conditions to which the license was subject.

The following residents had incomplete or late Assessment Protocols (APs)

completed:

i) An identified resident had an assessment completed with an identified ARD date in June 2016, however AP's related to an identified care area were not completed for 19 days after the ARD date. A second assessment was completed with an identified ARD date in August 2016, however some AP's were not completed for 28 days after the ARD date.

ii) An identified resident had an assessment completed with an identified ARD date in November 2016, however AP's related to an identified care area were not completed for 28 days after the ARD date.

iii) An identified resident had an assessment completed with an identified ARD date in December 2016, however AP's related to an identified care area were not completed for 33 days after the ARD date.

iv) An identified resident had an assessment completed with an identified ARD date in November 2016, however AP's related to an identified care area were not completed for 21 days after the ARD date. A second assessment was completed with an identified ARD date in January 2017, however AP's were not completed for 28 days after the ARD date.

v) An identified resident had an assessment completed with an identified ARD date in December 2016, however AP's related to an identified care area were not completed for 28 days after the ARD date.

vi) An identified resident had a MDS 2.0 Quarterly assessment completed on an identified date in November 2016, and coding on this assessment indicated the resident experienced an identified symptom. Registered staff #183 indicated that for non-triggered clinical conditions staff would document an assessment in the resident's progress notes. Registered staff #283 confirmed that a clinical note had not been documented in the progress notes and that a non-triggered RAP assessment of the identified symptom experienced by the resident had not been completed.

Registered staff #183 confirmed that a schedule for completing assessments was developed but they do not consistently meet the practice requirements of the RAI-MDS system.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

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 :

The licensee failed to ensure that were 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, procedure, strategy or system, the plan, policy, procedure, strategy or system was complied with.

1. In accordance with O. Reg. 79/10, s. 114(2) the licensee is required to ensure

that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and disposal of all drugs used in the home.
Staff did not comply with the following licensee's policies that were included in the medication management system:

a) The licensee's "Medication Errors" policy, identified as subsection 8.7 and last reviewed in August 2011 directed that:
- All medication errors would be recorded in the resident's clinical record.
- The resident's physician would be immediately notified.
- The resident's substitute decision maker would be notified.
- All details of the error were to be documented on the progress notes.
- Staff were to complete a Risk Management Report within the computerized documentation system.
- All medication errors will be reviewed by the Pharmacy and Therapeutics Committee who will make recommendations for improvement in the Medication Management System to prevent any further medication errors.

i) Staff did not comply with the above noted policy when a Medication Incident/Near Incident/Adverse Drug Reaction Report confirmed a medication incident involving an identified resident had occurred on an identified date in 2017. Registered staff administered a medication to the resident that was not in accordance with the directions for use specified by the prescriber. The Assistant Director of Care (ADOC) confirmed that a Risk Management Report had not been initiated related to this incident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #002773-17)

ii) Staff did not comply with the above noted policy when a Medication Incident/Near Incident/Adverse Drug Reaction Report confirmed a medication incident involving an identified resident had occurred on and identified date in 2017. Registered staff administered a medication to the resident that was not in accordance with the directions for use specified by the prescriber. A review of the computerized clinical record confirmed that staff had not document the details of this medication incident in the resident's progress notes.

iii) Staff did not comply with the above noted policy when a Medication Incident/Near Incident/Adverse Drug Reaction Report confirmed a medication incident involving an identified resident had occurred on an identified date in 2017.

Registered staff failed to administer a medication to the resident that the resident's physician had ordered the resident to receive. During a review of this incident with registered staff #168 and the ADOC, it was confirmed that there were no records in the resident's clinical record, the Doctor's Book or on the Medication Incident Report that staff had notified the resident's physician of the incident. Registered staff #168 and the ADOC confirmed there were no notations in the resident's clinical record or on the Medication Incident Report that staff had notified the resident's substitute decision maker and staff who discovered the incident had not document the details of the medication incident in the resident's progress notes or complete a Risk Management Report of this incident.

iv) Documentation provided by the home indicated that the Pharmacy and Therapeutics Committee did not review all medication incidents or make recommendations for improvement in the Medication Management System when they met on July 20, 2016, October 18, 2016 or January 18, 2017.

b) The licensee's "The Medication Pass" policy, identified as subsection 8.2 and last reviewed in September 2011 and the licensee's "Administration of Medication/Treatment" policy, identified as subsection 8.2 and last reviewed in September 2011, directed that following the administration of medication to the resident staff were to sign the Electronic Medication Administration Record (EMAR) on the computer screen in the proper space for each medication administered.

Staff did not comply with the above noted policies when it was documented in the identified resident's clinical record that the resident received an identified medication on an identified date, but the registered staff member who administered this medication failed to sign the medication as being given on the EMAR.

c) The licensee's "The Medication Pass" policy identified as subsection 8.2 and last reviewed in September 2011 directed staff to check each medication package and the medication label against the EMAR computer screen for accuracy.

Staff did not comply with the above noted policy when on and identified date in 2017, an identified resident was administered the incorrect medication. Interview notes maintained by the home confirmed that the registered staff member involved in this incident confirmed during an interview that they had not checked the medication label before administering the identified medication to the resident.

2. In accordance with O.Reg. 79/10, s, 53(1) the licensee is required to develop

written approaches to care that include protocols and strategies to meet the needs of residents demonstrating responsive behaviours.

The home provided a document titled "Responsive Behaviour Management" identified as 4.11.10 and last revised in March 2011, that contained the protocols and strategies staff were to follow when residents demonstrated responsive behaviour. This documented directed staff to:

a) Report all incidents of responsive behaviours that place the resident or others at risk, including resident to resident abuse immediately to the Ministry of Health and Long Term Care (MOHLTC).

- Staff did not comply with this written strategy when the home submitted a Critical Incident Report (CIR) on and identified date in 2016, which reported that five days earlier an identified resident had demonstrated a responsive behaviour towards a co-resident. This information was reported to MOHLTC five days after the incident had occurred.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #032191-16)

- Staff did not comply with this written strategy when the home submitted a CIR on an identified date in 2017, which reported that two days earlier an identified resident had demonstrated a responsive behaviour towards a co-resident. This information was reported to MOHLTC two days after the incident had occurred.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #000910-17)

b) The interdisciplinary team will analyze behaviours to identify triggers and consequences of the behaviour, develop therapeutic plans for behaviour management, document in the care plan, implement plan and provide ongoing monitoring and support for the resident as well as continue to monitor behaviour and effects of interventions.

- Staff did not comply with these written strategies related to an identified resident. Registered staff #168 confirmed that an attempt to identify possible triggers for responsive behaviours being demonstrated by the resident had not been made. Clinical documentation confirmed therapeutic plans had not been developed when the resident demonstrated two responsive behaviours. Registered staff #168 and registered staff #183 confirmed there had not been continued monitoring and

evaluation of the behaviours being demonstrated by this resident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #032191-16)

- Staff did not comply with these written strategies when registered staff #168 confirmed that an attempt to identify possible triggers for responsive behaviours being demonstrated by an identified resident had not been made and the interdisciplinary team had not met to discuss responsive behaviours being demonstrated by this resident. Clinical documentation confirmed that therapeutic plans had not been developed or implemented when this resident demonstrated two responsive behaviours. Registered staff #168 confirmed there had not been continued monitoring and evaluation of the behaviours being demonstrated by this resident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #000910-17)

3. In accordance with O. Reg. 79/10, s. 30(1) 1, the licensee is required to have an organized program for falls prevention and management that includes relevant policies, procedures and protocols.

The licensee's policy "Falls Prevention Program" identified as subsection 3.6 and last reviewed in June 2015. This policy directed that:

a) The interdisciplinary team will conduct a falls risk assessment.
Registered staff #166 and clinical documentation confirmed staff did not comply with this policy and interdisciplinary falls risk assessments had not been completed for two identified residents.

b) The Charge Nurse/Unit Manager is responsible for coordinating monthly (currently being held weekly) meetings with members of the care team, including registered nursing staff, PSW staff, Restorative staff, physiotherapy staff, dietary staff, activity and environmental staff.
Staff did not comply with this policy when staff on three resident home areas confirmed that staff attending the meetings were Registered Practical Nurses (RPN), PSW staff and no other members of the interdisciplinary team attended the meetings. Registered staff #612 confirmed that only staff working in the nursing department attended the meetings.

c) The team reviews all falls incidents, including medical history, drug record, the

resident's care plan and the Post Fall Incident Investigative Tool.
The DOC confirmed staff did not comply with this policy when documentation of Falls Prevention Meetings held on three resident home areas did not include evidence that the above noted factors were considered when reviewing fall incidents.

d) Resident care plan is reviewed and recommendation for safety are made by the team and included in the resident's care plan.
The DOC confirmed staff did not comply with this policy when minutes of these meetings held on three consecutive months in 2017, identify four residents who had fallen, however there were no recommendation made for changes to the resident's care plan identified or documented in record of the meetings.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #028384-16 and #001158-17)

4. In accordance with the LTCH Act 2007, c. 8, s. 21 the licensee is require to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and how the licensee deals with complaints.

The licensee failed to ensure that staff complied with the licensee's policy "Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes", identified as section 4.2, subsection 4.2.10 and last reviewed in March 2016, when they failed to comply with the following directions:

a) The Administrator (or designate) shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

i) Staff did not comply with this direction when the ADOC confirmed that there was not a record created following a complaint by a Personal Support Worker (PSW) that an identified resident had not been provided with care over what was identified as an extended period of time. This incident was reported to MOHLTC via a Critical Incident Report (CIR) under the category of neglect.

ii) Staff did not comply with this direction when the ADOC confirmed that there was not a record created following a complaint that an identified resident had sustained an injury while care was being provided.

b) The Administrator shall provide a written report to the Ministry of Health and Long Term Care using the Critical Incident Report within 10 business days of the incident that is to include a description of the incident, individuals involved, actions taken in response to the incident, the outcome or current status of the individuals who were involved in the incident, the analysis and follow-up actions, immediate actions that have been taken to prevent a recurrence and the long term plan to correct the situation.

Staff did not comply with this direction when it was reported on an identified date that an identified resident had sustained an injury while care was being provided. The ADOC, Nurse Consultant and documentation confirmed that a written report was not provided to the MOHLTC for 23 days after the incident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident #034757-16 and #034289-16)

c) The Administrator (or designate) shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action taken, time frames for action to be taken and any follow-up action required; final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant.

Staff did not comply with this direction when a document provided by the home identified as "Bella Senior Care Residence Complaint Log 2017" containing 32 identified complaints between January 1, 2017 and March 19, 2017, did not contain the following information about the items listed on the log:
-the type of action taken to resolve the complaint, including the date of the action taken, time frames for actions taken and any follow up action required
- the final resolution, if any, to the concerns identified
-a description of the response made to the complainant
-any response made in turn by the complaint.

5. In accordance with O. Reg. 79/10, s. 30(1)1 the licensee is required to ensure

that written policies and protocols are developed for the organized program of Nursing and Personal Care identified in section 8 of the Act.

Staff did not comply with the following policy that was included in the organized program of Nursing and Personal Care.
The licensee's "Safe Handling and Assessing Residents" policy, identified as subsection 4.6.1.d last revised in June 2013, directed that the procedure for turning a resident in bed was that staff were to cross the resident's arms over their chest and then roll the resident gently in the direction required.

Staff did not comply with this policy when on an identified date, a PSW was observed by another staff member to use unsafe positioning techniques when assisting an identified resident. The DOC confirmed that the positioning technique used by the PSW was not safe and not as is directed in the home's Safe Handling and Assessing Residents policy.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Inspection # 0005202-17) [s. 8. (1) (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 006

WN #6: 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 staff used safe transferring and positioning techniques when assisting residents.

a) Staff did not use safe transferring and positioning techniques when on an identified date in 2016 an identified resident was transferred which resulted in the resident sustaining an injury. Personal Support Worker (PSW) #604 and #605 confirmed that on the identified date that they did not safely position and transfer the resident which resulted in the resident falling and sustaining an injury.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Inspection # 032091-16)

b) Staff did not use safe positioning techniques when on an identified date in 2017, PSW #171 used an unsafe positioning technique to reposition an identified resident which resulted in the resident sustaining an injury. The DOC confirmed that the positioning technique used by PSW #171 was not a safe positioning technique and was inconsistent with the directions contained in the home's Safe Handling and Assessing Residents policy.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Inspection # 005202-17) [s. 36.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 007

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

a) Staff failed to assess an identified resident, attempt to identify behavioural triggers or implement interventions to prevent harmful interactions between this resident and a co-resident. The licensee submitted a Critical Incident Report (CIR) which indicated that the identified resident and a co-resident had engaged in a potentially harmful interaction on an identified date in 2016. Clinical documentation indicated that another potentially harmful interaction occurred six days later between the identified resident and the same co-resident. Registered staff #182 and the clinical record confirmed that no attempt had been made to initiate an interdisciplinary assessment, to identify possible triggers for the identified behaviour demonstrated by the identified resident or to identify and implement interventions to prevent a re-occurrence.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident # 032191-16)

b) Staff failed to implement interventions to prevent a harmful interaction between an identified resident and a co-resident.
On and identified date in 2017, the identified resident engaged in a potentially harmful interaction with a co-resident which resulted in the co-resident sustaining an injury. The co-resident's plan of care identified a care intervention to be put in place. Registered staff #613 and #182 confirmed that it was known by staff providing care to the identified resident that the intervention put in place in the co-resident's plan of care would not deter the identified resident, but took no action to ensure that potentially harmful interactions between these two residents would not occur either prior to the above noted incident or subsequent to the incident.

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 008

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the annual evaluation of the matters referred to in O. Reg. 79/10, s. 53(1), including a summary of the changes made and the dates those changes were implemented. The home provided a document titled "Behavioural Support Program: Annual Assessment Tool" and confirmed that this document represented the home's 2016 annual program review of the Behaviour Support Program. The document indicated that this annual review was not completed by an interdisciplinary team, it was signed by one registered staff member and dated December 31, 2016. The document identified 10 negative responses related to program organization, data collection and analysis as well as staff training. The Administrator confirmed that although program data had been collected, plans to address the negative responses had not been made and the program had not been updated based on the findings in this annual review. [s. 53. (3) (c)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours that behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to the behaviours, where possible and actions were taken to respond to the needs of the resident, including assessments and reassessments.

a) An identified resident's clinical record confirmed that the resident demonstrated three responsive behaviours towards staff and co-residents.
i) Registered staff #182 and clinical documentation confirmed that staff in the home did not utilize a behaviour tracking mechanism that would allow staff to collect data in order to identify possible triggers for responsive behaviour and there had been no attempt to identify triggers for the responsive behaviours demonstrated by this resident.

ii) Registered staff #182 and clinical documentation confirmed that strategies had not been developed or implemented to respond to responsive behaviours being demonstrated by this resident.

-The identified resident's clinical record confirmed that the resident demonstrated a responsive behaviour towards a co-resident on an identified date in 2016 and then again six days later. The clinical record confirmed that there was no documentation in the resident’s plan of care to indicate that strategies had been developed or implemented to manage this responsive behaviour demonstrated towards this co-residents.

- Staff providing care to the identified resident indicated that the resident demonstrated a second responsive behaviour related to care. The clinical record confirmed there was no documentation in the resident's plan of care to indicate that strategies had been developed or implemented to ensure that care plan directions were followed and the resident received the care specified in the plan of care.

- The clinical record confirmed that the identified resident demonstrated a third responsive behaviour related to the implementation of a medical regime. A review of the clinical record confirmed that the resident demonstrated this behaviour during an identified month in 2016. The clinical record confirmed there was no documentation in the resident's plan of care to indicate that strategies had been developed or implemented to manage the responsive behaviour demonstrated by this resident related to the implementation of a medical regime.

iii) Registered staff #177 confirmed that actions had not been taken to assess and reassess an identified resident in relation to the ongoing demonstration of responsive behaviours.
Registered staff #182 and clinical documentation confirmed that the resident's plan of care related to responsive behaviours identified a reassessment period of three months and that the staff had not reassess the resident's responsive behaviours at any time other than the scheduled quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) mandatory assessments. Registered staff #177 and clinical documentation confirmed that when two consecutive RAI-MDS mandatory assessments were completed for this resident, a reassessment of the behaviours being demonstrated by the resident had not been undertaken, an evaluation of the effectiveness of care being provided related to the responsive behaviours had not been undertaken and there were no changes to the resident's plan of care related to three responsive behaviours demonstrated by this resident.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident # 032191-16)

b) Registered staff #182 and clinical documentation confirmed that staff providing care to an identified resident were aware of four responsive behaviours being demonstrated by the resident. Registered staff #182 confirmed that the home did not utilize a process for the identification of potential behavioural triggers and although the resident's plan of care included the above noted responsive behaviours staff had not attempted to identify triggers for the behaviours being demonstrated by this resident.

(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident # 000910-16) [s. 53. (4)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 009

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) An identified resident was administered a drug that was not in accordance with the directions for use specified by the prescriber. The Assistant Director of Care (ADOC), clinical documentation, records maintained by the home and a Critical Incident Report (CIR) submitted to the Ministry of Health and Long Term Care (MOHLTC) confirmed the resident' physician had ordered the resident to receive

an identified drug at a specific time. The above noted documents confirmed that on an identified date in 2017, a registered staff member administered a different drug that was not prescribed to be given to the resident at that time. The registered staff member immediately recognized the situation and took action related to this in incident.
(PLEASE NOTE: The above noted non-compliance while completing an inspection of Critical Incident Inspection # 002773-17)

b) An identified resident was administered a drug that was not in accordance with the directions for use specified by the prescriber. Registered staff #167, clinical documentation and a Medication Incident Report provided by the home confirmed that the resident's physician had ordered the resident to receive an identified drug twice daily. The Medication Administration Record (MAR) indicated that the scheduled times for the administration of this drug were 0800 hours (hrs.) and 2000 hrs. Registered staff worked during the day on an identified date in 2017, administered the medication as ordered at 0800hrs and administered the medication again at 1900 hours. The Registered staff who administered the medication at 1900hrs did not document the administration of this medication in the resident's Medication Administration Record (MAR). Registered staff #167 confirmed that on the identified date, they administered the 2000hrs dose of this medication because they were unaware that the registered staff working days had administered the 2000hrs dose of the medication at 1900hrs. Registered staff #167 and pharmacy records provided by the home confirmed that the resident received this medication at 0800hrs, 1900hrs and 2000hrs instead of the two times a day this medication was ordered to be administered.

c) An identified resident was administered a drug that was not in accordance with the directions for use specified by the prescriber. The ADOC, clinical documentation and a Medication Incident Report provided by the home confirmed that the resident's physician had ordered the resident to receive an identified drug twice a day and the MAR identified that this medication was to be administered at 0800hrs and at 1700hrs. The MAR and other records maintained in relation to drug administration confirmed that on an identified date in 2017 the resident received this medication in the required dose at 0756hrs and did not receive the second scheduled dose of this medication as was prescribed by the resident's physician.

d) An identified resident's physician ordered the resident to receive an identified drug. The clinical record confirmed that the above noted order was written in 2016, and was a current active order at the time of this inspection.

i) On an identified date in 2016, registered staff documented in the clinical record that they were unable to confirm that the resident received the drug as ordered by the residence's physician.
ii) A day following the above noted incident registered staff documented in the clinical record that they were unable to confirm that the resident received the drug as ordered by the resident's physician.
iii) Eleven days following the above note incident registered staff documented in the clinical record that they were unable to confirm that the resident received the drug as ordered by the resident's physician.
On the above three noted occasions staff did not ensure that a drug was administered to the identified resident as specified by the resident's physician.
(PLEASE NOTE: The above noted non-compliance related to the administration of medication was identified while completing an inspection of Critical Incident # 032191-16) [s. 131. (2)]

Additional Required Actions:

CO # - 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 010

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee did not immediately investigate two reported incident that involved an identified resident and that were identified by the staff in the home as physical abuse and neglect.

a) It was reported to a Registered Practical Nurse (RPN) on an identified date in 2016, that the identified resident had been abused by staff who provided care on an identified date and as a result the resident sustained an injury. A progress note written in the resident's clinical record the following day, indicated that the Registered Nurse and the Director of Care were notified of the incident and the home submitted a Critical Incident Report (CIR) to the Ministry 23 days after the reported incident. The CIR identified that the home was notifying the Ministry of an incident of staff to resident-physical abuse. The ADOC and the Nurse Consultant confirmed that they were unable to locate any documentation to confirm that an investigation into this incident was immediately initiated.

b) A Personal Support Worker (PSW) reported to the Registered Practical Nurse (RPN) on and identified date in 2016 that they believed the resident had be neglected because care required by the resident had not been provided over what was believed to be an extended period of time. Staff in the home submitted a CIR on the same day the incident was reported. The CIR indicated that the home was notifying the Ministry of an incident of staff to resident neglect. At the time of this inspection the home was unable to provide any documentation to verify that an investigation into this reported incident was immediately initiated. PSW #603 and PSW #604 who were identified as involved in the incident, confirmed that they recalled being interviewed by the Assistant Director of Care (ADOC), but indicated they were not contacted or interviewed on the day of the incident or the day immediately following the reported incident and the home was unable to provide any documentation to confirm that an investigation into this incident was immediately initiated.
(PLEASE NOTE: The above noted non-compliance related to the requirement to immediately investigate reports of abuse/neglect were identified while completing an inspection of Critical Incident #034757-16 and #034289-16) [s. 23. (1) (a)]

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 and ensuring that the licensee immediately investigate every alleged, suspected or witnessed incidents of abuse and neglect, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day with respect to the resident.

1. An identified resident's plan of care was not based on an assessment of behaviour patterns.
The resident's plan of care included a care focus related to continence care.

Personal Support Worker (PSW) #603 and PSW #604 confirmed that the resident was well known to demonstrate a responsive behaviour related to continence care. Registered Practical Nurse #608 confirmed that an assessment of responsive behaviours being demonstrated by this resident had not been completed before developing a care focus related to continence care and there were no care directions included in the plan of care for the management of responsive behaviours demonstrated by the resident related to continence care.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Inspection # 034757-16) [s. 26. (3) 5.]

2. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, interdisciplinary assessment of safety risks.

a) An identified resident's plan of care was not based on an interdisciplinary assessment of safety risks related to falling.
Registered staff had not assessed the resident's risk for falling before they developed a care focus indicating the resident was a risk for falls. On an identified date in 2016 registered staff documented generic data that was not specific to this resident on a Falls Risk Assessment Tool. Registered staff #166 confirmed that data collected on the identified tool was not specific to this resident, registered staff had not documented specific factors that placed this resident at risk, staff had not followed the licensee's policy for completing an assessment of the risk for falling and there was no documentation in the clinical record to indicate that other disciplines participated in a falls risk assessment for this resident. Care plan interventions put in place did not reflect factors that placed this resident at risk for falling, the plan of care was not effective in managing the risk of falling for this resident and the resident continued to fall.
(PLEASE NOTE: The above noted non-compliance while completing an inspection of Critical Incident Inspection # 028384-16)

b) An identified resident's plan of care was not based on an interdisciplinary assessment of safety risks related to falling.
Registered staff had not assessed the resident's risk for falling before they developed a care focus indicating the resident was a risk for falls. On an identified date in 2017, registered staff documented generic data that was not specific to this resident on a Falls Risk Assessment Tool. Registered staff #166 confirmed that data collected on the identified tool was not specific to this resident, registered staff had not documented specific factors that placed this resident at risk, staff had not followed the licensee's policy for completing an assessment of the risk for falling

and there was no documentation in the clinical record to indicate that other disciplines participated in a falls risk assessment for this resident. Care plan interventions put in place did not reflect factors that placed this resident at risk for falling, the plan of care was not effective in managing the risk of falling for this resident and the resident continued to fall.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Inspection # 001158-17) [s. 26. (3) 19.]

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 and ensuring compliance with O. Reg. 79/10, s. 26 (3) 5 and 26 (3) 19, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that staff complied with the written policy to minimize the restraining of residents.

The licensee's policy "Restraints" identified as subsection 4.1.3, last reviewed in December 2015 directed:

a) Staff were to "apply the restraint/Personal Assistive Service Device (PASD) ordered by the physician according to manufacturer's directions".

Staff did not comply with this direction on an identified date in 2017, when an identified resident was noted to be restrained with a loose fitting device. Registered staff #612 confirmed that the device had not been applied according to manufacturer's directions when it was noted that there was a four inch gap between the resident's body and the device. Personal Support Worker #178 confirmed that when they assisted the resident they felt the device was too tight and they loosened the device.

b) "The Administrator or designate shall conduct an annual review and evaluation of the facility's restraint reduction program, to ensure that the education strategies are effective and to implement identified improvements".

The Administrator or designate did not comply with this direction when a document identified as the Restraint Reduction Program: Annual Assessment Tool, completed on December 28, 2016, did not identify or implement changes to improve the six program areas that received negative evaluations and comments. [s. 29. (1) (b)]

]

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 and ensuring staff comply with the written policy to minimize the restraining of residents, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriated police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident.
a) Police were not immediately notified when staff in the home suspected that an identified resident had been neglected on an identified date in 2016. The home forwarded a Critical Incident Report (CIR) to the Ministry to notify the Ministry that the home suspected the resident had been neglected. The home did not subsequently amend the report sent to the Ministry or indicate in any way that they no longer suspected that the resident had been neglected by staff and the Assistant Director of Care (ADOC) confirmed that the police had not been notified of the home's suspicion that a resident had been neglected.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of a Critical Incident Inspection #034757-16)

b) Police were not immediately notified when staff in the home suspected that an identified resident had been physically abused on an identified date in 2016. The home forwarded a CIR to the Ministry to notify the Ministry that the home suspected the resident had been physically abused by staff. The home did not subsequently amend the report or indicate in any way that they no longer suspected that the resident had been physically abused by staff and the clinical record as well as the ADOC confirmed that the police had not been notified of the home's suspicion that the resident had been physically abused by staff.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of a Critical incident Inspection #034289-16) [s. 98.]

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 and ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed incidents of abuse or neglect of a resident, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was kept in the home that included:
(a) the nature of each verbal or written complaint;

(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

The Administrator failed to provide a documented record of every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home when a request was made through the Assistant Director of Care (ADOC) to produce the record of complaints made between October 1, 2017, up to and including the date the request was made on February 9, 2017. The ADOC confirmed on February 10, 2017, that the record was not available. On March 21, 2017, the ADOC provided a document identified as "Bella Senior Care Resident Complaint Log 2017" which identified complaints logged from January 1, 2017, to March 19, 2017. The Administrator later confirmed that this record was not available at the time of the request and that the document provided did not meet the legislated requirements.
The document noted above did not contain the type of action taken to resolve the complaints, including the dates of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response or any response made in turn by the complainant. [s. 101. (2)]

2. The licensee failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly.
The Administrator confirmed that records used to create a documented identified as "Bella Senior Care Residence Complaint Log 2017 were not reviewed or analyzed for trends at least quarterly. [s. 101. (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 and ensuing that the licensee complies with O. Reg. 79\10, s. 101(2) and 101(3), to be implemented voluntarily.

WN #15: 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 a missing or unaccounted for controlled substance.

Documentation made by registered staff in an identified resident's clinical record indicated that on nine occasions, over a three month period of time, staff were unable to locate an identified controlled substance. When reporting required information to the Director, long term care homes utilize the computerized Critical Incident System. A review of Critical Incident Reports submitted by the licensee during the above noted period of time, confirmed that the above noted incidents where staff were unable to account for an identified controlled substance, had not been reported to the Director.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident # 032191-16) [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 and ensuring that the Director is informed of a missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a restraining device that was included in an identified resident's plan of care was applied according to manufacturer's instructions.

On an identified date in 2017, an identified resident was noted to have a loosely applied restraining device applied. RPN #612 confirmed that the restraining device had not been applied according to manufacturer's instructions and there was a four inch gap between the resident's body and the device. Personal Support Worker (PSW) #178 confirmed that when they assisted the resident, they felt that the device was too tight and loosened the device.
The resident's plan of care directed that the resident required the use of the device as part of a falls prevention intervention. At the time of this inspection RPN #612 confirmed that the resident continued to require the use of the device. [s. 110. (1) 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 and ensuring that when a resident is restrained by use of a physical device, the device is applied according to manufacturer's instructions, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs stored in a medication cart that was secured and locked.
On February 13, 2017, the medication cart on the Legends home area was left unlocked and unsecured in the dining room. At 1310 hours (hrs.) on the noted date it was observed that the medication cart was positioned just inside the doors to the dining room and the medication cart was not locked. Registered Staff #607 was noted to be sitting with their back to the medication cart assisting a resident. After approximately five minutes staff #607 turned towards the medication cart when another resident spoke and when it was pointed out that the medication cart was not locked they indicated that they were unaware it was unlocked. This incident took place towards then end of the meal service when staff and residents were leaving the dining room after having finished their noon meal. Staff, residents or visitors walking in the hall or in and out of the dining room would have had the opportunity to access the contents of the medication cart. [s. 129. (1) (a)]

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 and ensuring that drugs are stored in a medication cart that is secured and locked, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the every medication incident involving a resident was reported to the resident's substitute decision-maker and the resident's physician.
Staff, clinical documentation and records maintained by the home confirmed that on an identified date in 2017, a medication incident occurred when an identified resident was not provided with a medication that had been specifically ordered by the resident's physician. Following a review of documents provided by the home and a review of computerized clinical record, it was confirmed that there was no documentation to indicate that the resident's substitute decision maker or the resident's physician were notified of this incident. [s. 135. (1)]

2. The licensee failed to ensure that a written record was kept of the quarterly review of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review and that any changes and improvements

identified in the review were implemented.
The Director of Care (DOC) confirmed that the quarterly review of medication incidents would take place at the Professional Advisory Committee (PAC) meetings that were held every three months in the home. The home provided the minutes of the previous three meetings of this committee. The PAC meeting minutes for July 20, 2016, indicated that there were a total of 12 medication incidents recorded for the previous three months and there was no documentation in these minutes to indicated that a review of these identified medication incidents had occurred or what changes and improvements would be implemented to reduce and prevent further medication incidents. The PAC meeting minutes for October 18, 2016, indicated that there were a total of four medication incidents recorded for the previous three months and there was no documentation in these minutes to indicated that a review of these identified medication incidents occurred or what changes and improvements would be implemented to reduce and prevent further medication incidents. The PAC meeting minutes for January 18, 2017, indicated that there were no medication incidents that resulted in harm to residents. At the time of this inspection the home provided a number of Medication Incident Reports that occurred in the three months preceding the PAC meeting held on January 18, 2017, but there was no documentation to indicated that a review of the incidents documented on these Medication Incident Reports were reviewed or what changes and improvements would be implemented to reduce and prevent further medication errors.
At the time of this inspection the home was unable to provide documentation to confirm that over the previous nine month period of time all medication incidents that had occurred were reviewed or what actions would be implemented to reduce or prevent medication incidents. [s. 135. (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 and ensuring the licensee complies with O. Reg. 79\10, s., 135(1) and 135(3), to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Falls Prevention and Management Program, which is a required program, was evaluated and updated at least annually in accordance with evidenced-based practice and if there are none in accordance with prevailing practices.

At the time of this inspection the home provided a document titled "Falls Management Program: Annual Assessment Tool" which was dated December 28, 2016, and confirmed by management staff to be the 2016 annual review of the licensee's falls prevention and management program. A review of this document indicated that a number of recorded comments indicated the that the program was not functioning as expected, however the document did not contain any changes or improvements that would be made based on the review. Comments documented on the tool included: weekly team meetings were not being held, teams were not monitoring interventions for residents who frequently fall, the Administrator and DOC were not periodically attending meetings to monitor falls data at least monthly, recreation and leisure programs were not consistently provided to residents who fall and monthly falls analysis was not occurring and feedback about falls was not consistently provided to direct care staff each month. At the time of this inspection the home was unable to provide any documentation to confirm that actions were put in place to address issues identified on the above noted document. [s. 30. (1) 3.]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that the 2016 evaluation of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents included what changes and improvements were required to prevent further occurrences.

At the time of this inspection the home provided a document titled "Abuse and Neglect Prevention Program: Annual Assessment Tool" which was confirmed by management staff to be the 2016 annual review of the licensee's policy to promote zero tolerance of abuse and neglect of residents. A review of this document indicated that a number of recorded comments indicated the that the program was not functioning as expected, however the document did not contain any changes or improvements that would be made based on the review. Comments documented on the tool included: staff unaware of who is responsible for Abuse and Neglect Prevention Program, poor tracking and follow-up for all episodes of abuse and neglect, not all incidents have been followed up in a timely manner, mandatory reporting not followed, staff not removed from caring for resident and sent home during investigation, mandatory reporting not completed, improved reporting to the Medical Director is imperative and not all mandatory reports were forwarded to the Ministry. Five of the eight staff who signed the above noted document were interviewed and these staff vaguely recall discussing abuse and neglect prevention. All five staff confirmed they were unaware of any plans developed to address the comments made on the document. [s. 99. (b)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,

(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;

(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;

(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;

(d) that the changes or improvements under clause (b) are promptly implemented; and

(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the act and this Regulation.
Staff in the home did not complete an annual review to determine the effectiveness of the written policy to minimize the restraining of residents. The Nurse Consultant provided a document identified as "Restraint Reduction Program: Annual Assessment Tool", dated December 28, 2016, and confirmed the document represented the 2016 annual review of the home's policy to minimize the restraining of residents. A review of the document indicated that six areas of this review received negative responses. The following areas of the review were responded to with a "No" indication: Effective team problem solving to develop and monitor interventions for restrain reduction within the facility; Administrator and DOC review restraint indicator data at least monthly; Celebration of success stories and rewards for caregivers who reduce restraints; There is evidence that the number of restraints in use has decreased and the least restrictive restrain is in use; Restraint data reported to Medical Advisor Physician, and Feedback about restraint reduction given to direct care staff each month.
The Nurse Consultant and the DOC confirmed, at the time of this inspection, there was no indication or documentation that changes or improvements were considered or implemented to minimize restraining based on the negative data collected about the implementation of the policy. [s. 113. (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a Registered Dietitian who is a member of the staff of the home, meets annually to evaluated the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

At the time of this inspection it was confirmed by the Nurse Consultant that a meeting was not held to complete an annual evaluation of the effectiveness of the medication management system for the year 2016. [s. 116. (1)]

Issued on this 11 day of June 2017 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LISA VINK (168) - (A1)

Inspection No. / No de l'inspection : 2017_587129_0002 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 028384-16, 029382-16, 029657-16, 032091-16, 032191-16, 034289-16, 034757-16, 000910-17, 001158-17, 001376-17, 002773-17, 002983-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jun 11, 2017;(A1)

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

Ontario

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Michael Bausch

---

To BELLA SENIOR CARE RESIDENCES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

1. The license shall develop and implement a mechanism/process that will ensure all staff providing direct care to residents are aware of the specific care to be provided to the resident for whom they have been assigned to provide care.

2. All resident's plans of care, including resident #009 and resident #010 are to be reviewed to ensure that care plan interventions meet the current needs of the resident and are included in the above mentioned mechanism/process.

3. The licensee shall develop and implement a schedule for the evaluation of the effectiveness of the mechanism/process in ensuring the care identified in the plan of care is being provided to the resident's as specified in the plan of care.

Grounds / Motifs :

1. The licensee has failed to comply with order #001 from inspection # 2016_250_001 served on November 23, 2016.
This Order is based on the application of the factors of severity (2), scope (1) and

compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm to residents, the scope of isolated incidents and the licensee's history of non-compliance that included the issuing of two Written Notifications in November 2016 and January 2017, seven Voluntary Plans of Correction in February 2015, March 2016, May 2016, July 2016, August 2016, September 2016 and November 2016 and two Compliance Orders in July 2014 and July 2016.

2. Registered staff did not ensure the care set out in the plan of care was provided to an identified resident as specified in the plan, in relation to the following:
i) The identified resident's plan of care included a care focus which indicated the resident was at risk for falling and care plan interventions were put in place to decrease the number of falls experienced by the resident. At the time of this inspection registered staff #613 confirmed that the interventions identified in the plan of care were not in place. Staff did not ensure that the care specified in the plan of care related to falls management was provided to the resident.

3. Registered staff did not ensure the care set out in the plan of care was provided to an identified resident as specified in the plan, in relation to the following:
i) The Director of Care (DOC) directed all registered staff to implement a twice daily observation related to a specific treatment and this direction was added to the resident's plan of care. The clinical record contained directions that staff were to observe the specific treatment ordered for the resident and document that they had completed this in a specified part of the resident's plan of care. A review of the resident's clinical record indicated that registered staff documented on seven days during an identified month in 2016 and three days during the following month that the resident refused to allow staff to observe the specific treatment. Registered staff #612 confirmed that the resident often refused to let them observe the specific treatment, they did not take any action beyond the first attempt to observe the treatment and there was not an alternate plan in place to ensure the directions to observe the specific treatment were complied with.

ii) The identified resident's plan of care specified that the resident was to have an identified procedure completed daily. On an identified date the resident was observed and it was noted that the procedure had not been completed. Personal Support Worker (PSW) #611 confirmed that the resident had not had the procedure completed and that the resident would often demonstrate a responsive behaviour when staff attempted to complete the procedure. Registered staff # 612 confirmed

that they had not been informed that the resident had demonstrated responsive behaviours related to this procedure when the above noted observation was made and documentation made by PSWs in the days preceding the above noted date did not indicate that the resident had demonstrated responsive behaviours related to this procedure. On a second identified date the resident was observed and it was noted that the resident had not had the procedure completed. The date following this identified date PSW #178 confirmed that they had not provided the procedure on the preceding day. Staff failed to ensure the resident was provided care related to an identified procedure as directed in the resident's plan of care.

iii) The identified resident's plan of care indicated the resident was at risk for falling. The plan of care specified that staff were to ensure the call bell was accessible to the resident and encourage the resident to call for assistance. On an identified date the resident was observed and it was noted that the call bell was not accessible to the resident. PSW staff #611 confirmed the resident was not able to reach the call bell to call for assistance. Staff failed to ensure that care was provided to the resident as specified in the plan of care.

iv) The identified resident's plan of care included directions for the management of a care device. The plan of care provided three specific directions for staff related to the identified device. On two identified dates the resident was observed and it was noted that the directions identified in the plan of care had not been implemented. Staff failed to ensure that care was provided as specified in the plan of care related to the management of a care device.
(PLEASE NOTE: The above noted non-compliance was identified while completing an inspection of Critical Incident Log # 032191-16)

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Ontario

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 des Soins de longue durée

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 : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

1. The licensee shall provide training to all staff involved in the assessment/reassessment of residents. The training is to include the steps staff are to follow when reassessing a resident, the relationship between the established goals of care and the timing of reassessments, how to identify that the care being provided to the resident has not been successful, where assessment/reassessment data is to be documented and the requirement to review and revise the plan of care following a reassessment.

2. The licensee shall develop and implement a schedule for monitoring staff's performance in complying with directions for the assessment/reassessment of residents.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (3), scope (2) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of actual harm experienced by two residents, the scope a pattern of

incidents and the licensee's history of non-compliance that included the issuing of two Written Notifications in March 2015 and November 2016, two Voluntary Plans of Correction in February 2015, March 2016 and one Compliance Order in July 2016.

2. An identified resident was not reassessed and the plan of care was not reviewed and revised when the resident's care needs changed in relation to continence and responsive behaviours.
Staff and clinical documentation confirmed that the resident's plan of care was not reviewed and revised when the resident's care needs related to continence changed. During interviews, RPN #608, PSW staff #603 and PSW staff #604 confirmed that the resident's continence had changed. At the time of this inspection, RPN #603 confirmed the resident's plan of care did not indicate a change in continence and there was no indication that the resident demonstrated responsive behaviours. Minimum Data Set (MDS) data collected during an identified month in 2017, confirmed that the resident continence had changed. Registered staff #608, the Nurse Consultant and the clinical record confirmed that the resident's plan of care had not be reviewed or revised when the resident's continence care needs and patterns changed or when the resident began demonstrating a responsive behaviour.

3. An identified resident's plan of care was not reviewed or revised when the care identified to prevent falls was not effective and the resident continued to fall.
The resident's plan of care indicated that the resident was a risk for falling. The goal of care initiated on an identified date in 2014, indicated that this resident would have no further falls. A review of clinical documentation over a five month period of time prior to an identified date in 2016, indicated the resident fell seven times over the five month period of time. Injuries sustained during these falls were documented in the resident's clinical record. At the time of this inspection registered staff #166 confirmed that during the five month period of time identified above the goal of care for this resident related to falls was not reassessed and there were no new care interventions put in place to prevent further falling or minimized the risk of injury from falling for this resident.

4. An identified resident's plan of care was not reviewed or revised when the care identified to prevent falls was not effective and the resident continued to fall.
The resident's plan of care indicated that the resident was a risk for falling. The goal of care initiated on an identified date in 2016, indicated that this resident would have no falls. A review of clinical documentation over a five month period of time prior to

an identified date in 2017, indicated that the care being provided had not been effective when it was documented that the resident fell seven times over the five month period. Injuries sustained during these falls were documented in the resident's clinical record. At the time of this inspection registered staff #166 confirmed that the resident's plan of care was not reviewed or revised until after the resident had fallen six times.

5. An identified resident was not reassessed and the plan of care was not reviewed or revised when the care being provided related to responsive behaviours was not effective.
Registered staff #168 confirmed that the resident was not reassessed and the resident's plan of care was not reviewed or revised when it was identified that the care being provided to the resident had not been effective in relation to two behavioural goals that had been established for this resident.
i) The resident's plan of care included a goal related to an identified responsive behaviour and interventions put in place to accomplish this goal were initiated and/or revised twice in 2015 and once on an identified date in 2016. Clinical records indicated that incidents of the identified responsive behaviour occurred in 2016, and twice in 2017. Registered staff #168 confirmed that the resident had not been reassess and the care plan was not reviewed or revised when the resident continued to demonstrate the identified responsive behaviour.
ii) The resident's plan of care included a goal related to a second responsive behaviour. Interventions put in place to accomplish this goal were initiated and/or revised in 2016. Clinical records indicated that the resident demonstrated the identified behaviour on an identified date in 2016, 46 times during an identified month in 2017 and 24 times during a second identified month in 2017. Registered staff #168 confirmed that the resident had not been reassess and the care plan had not been reviewed or revised when the resident continued to demonstrate the identified responsive behaviour.

6. An identified resident was not reassessed and the plan of care was not reviewed and revised at least every six months related to pain and pain management. Three consecutive quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) coding activities completed in 2016 indicated that pain the resident experienced had changed both in relation to intensity and frequency. Documentation in the clinical record indicated the resident received medication throughout the above noted periods of time.
Registered staff #183 indicated that following RAI-MDS coding activities noted

above, if a care area such as pain did not trigger a Resident Assessment Protocol (RAP) document, staff completing the RAI-MDS activity would complete a non-triggered RAP note in the resident's progress notes in order to complete an assessment/reassessment of pain. A review of progress notes confirmed that a clinical note had not been written by staff related to the pain care focus. There was no documentation in the resident's clinical record to indicate a reassessment of the effectiveness of the pain management strategies had been attempted. Registered staff #183 confirmed the effectiveness of the plan of care being provided to the resident to manage pain had not been reassessed over a 10 month period of time in 2016.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

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 :

1. The licensee shall review and were necessary revise the policies and procedures related to Abuse and Neglect Prevention.

2. The licensee shall provide training for all staff related to the policies and procedures noted above. Attendance records are to be maintained in relation to this training.

3. The licensee shall develop and implement a program for monitoring staff's performance in complying with the licensee's policy.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (2), scope (2) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm, the scope of a pattern of incidents and the licensee's history of non-compliance that included the issuing of five Voluntary Plans of Correction in May 2015, March 2016, June 2016, July 2016 and August 2016.

2. The licensee failed to ensure staff complied with the licensee's policy "Abuse and Neglect Prevention" identified as section 4.1., subsection 4.1.2. last reviewed in January 2013.

a) Any staff/volunteer witnessing or having knowledge of an alleged/actual abuse or becoming aware of one shall immediately report it to his/her immediate Manager, Director of Care or the Administrator.

Registered staff #170 confirmed that on an identified date in 2017, Personal Support Worker (PSW) #171 reported an incident of staff to resident abuse during which the identified resident received an injury. The resident's clinical record confirmed that the resident had sustained an injury as a result of the noted incident. Registered staff #170 confirmed in a written response to the Director of Care (DOC) that they had not reported this incident to their immediate supervisor, the DOC or the Administrator. Staff failed to comply with this policy when they did not immediately report the above noted allegation of abuse.

b) An investigation shall be commenced immediately.

i) Staff did not comply with this direction when they did not immediately investigate an incident that was reported as staff to resident neglect through the submission of a Critical Incident Report (CIR) on an identified date in 2016. At the time of this inspection the home was unable to provide evidence that an investigation had been immediately commenced. Personal Support Worker (PSW) #603 and PSW #604 who were identified as involved in the incident, confirmed that they recalled being interviewed by the Assistant Director of Care (ADOC), but they were not contacted or interviewed on the day of or the day immediately following the reported incident. Staff failed to comply with this policy when they did not immediately investigate an allegation of neglect.

ii) Staff did not comply with this direction when they did not immediately investigate and incident that was identified as staff to resident physical abuse. It was reported to a RPN on an identified date in 2016, that the resident had an injury and that the resident reported the injury had occurred when staff were providing care on an identified date. Clinical documentation indicated that at the time of the incident the resident had described how the injury had occurred. A progress note written in the resident's clinical record as a late entry the day following the incident indicated that the Registered Nurse (RN) and the Director of Care (DOC) were notified of the incident. At the time of this inspection the ADOC and the Nurse Consultant confirmed that they were unable to locate any documentation to confirm that an investigation into this incident was immediately initiated. Staff did not comply with this policy when they did not immediately investigate an allegation of abuse.

c) Registered Nursing Staff/Director of Care shall document a detailed description of the incident in the resident's clinical record.

Staff did not comply with this direction when they did not document a detailed description of an incident that occurred on an identified date, which was reported to the Ministry of Health and Long Term Care (MOHLTC) on a Critical Incident Report (CIR). The CIR indicated that the incident was reported as "staff to resident neglect" involving an identified resident. At the time of this inspection a review of the resident's clinical record confirmed that staff had not documented a description of the incident the home had reported to the Ministry.

d) Administrator/Designate shall notify the Ministry of Health and Long Term Care (MOHLTC) immediately via the Critical Incident System or via pager (after hours or

holidays) of any Abuse/Suspected Abuse/Alleged Abuse.

Staff did not comply with this direction when they did not notify the MOHLTC of a suspected abuse when it was reported on an identified date, that a resident had sustained an injury, as a result of staff action during the provision of care. A progress note written in the resident's clinical record as a late entry the day following the incident, indicated that the Registered Nurse and the Director of Care were notified of the incident. This incident was reported 23 days after the identified incident when the home submitted a CIR to MOHLTC, which indicated that the home was reporting an incident of staff to resident physical abuse.

e) Administrator/Designates shall notify the police immediately of any alleged, suspected or witnessed incidents that the home may suspect constitute a criminal offence.

Staff did not comply with this direction when police were not notified of an incident that was reported to the home on an identified date. It was reported to a RPN that an identified resident had sustained an injury that was the result of a PSW providing care to the resident. At the time of the incident the resident was able to explain how the injury had occurred. A progress note written in the resident's clinical record as a late entry the day following the incident, indicated that the Registered Nurse and the Director of Care were notified of the incident. The home submitted a CIR to MOHLTC which indicated they were reporting an incident of staff to resident physical abuse. The ADOC confirmed that at no time were police contacted about this incident.

(129)

Ontario

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 84. s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Order / Ordre :

1. The licensee shall review and were necessary revise the policies and procedures that make up the quality improvement and utilization review system.

2. The licensee shall implement the quality improvement and utilization review system, ensure that activities are being monitored and documentation is maintained to demonstrate the policies and procedures are being followed and all the quality activities that are required in the LTCH Act 2007 and the associated Regulations are complied with.

Grounds / Motifs :

1. The licensee has failed to comply with order #004 from inspection

#2016_250511_0011 served on November 23, 2016.
This Order is based on the application of the factors of severity (2), scope (3) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the minimal harm/potential for actual harm, the widespread scope of the non-compliance and the licensee's history of non-compliance that included the issuing of a Compliance Order in July 2016.

2. The licensee failed to implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home.

Directions for implementation of the licensee's quality improvement and utilization review system are identified in three documents located in the Bella Senior Care Residence Quality and Risk Management Manual. These documents include: "Quality Committee", identified as section 3.0, subsection 3.1 and last reviewed/revised in September 2011; "Quality Process", identified as section 1.0, subsection 1.2 and last reviewed in September 2011 and "Quality Audits", identified as section 5.0, subsection 5.1 and last reviewed in September 11, 2011.

a) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Committee".
The preamble of this document set out a structure to be implemented to ensure the governance responsibilities for quality improvement were fulfilled. The structure identified that the governing body (licensee) had the ultimate responsibility for the quality of care and services and the management of risk, the Management Company had delegated responsibility and authority to the Administrator on issues and accomplishments related to quality improvements, the Administrator with the support of the Quality Committee and senior leadership submits quarterly reports to the Manager on quality improvement initiatives and activities for risk management and the responsibility for executing the components of the quality system and procedures are delegated to the Quality Care Teams.
At the time of this inspection the licensee had not ensured that the structure identified in the "Quality Committee" policy had been implemented.

i) The Administrator confirmed that support and direction had not been provided to

the Quality Care Teams related to the quality improvement process identified in the licensee's policies. The Administrator acknowledged that the Quality Care Teams submitted documentation that indicated they had collected data with respect to identified care areas, but had not analyzed the data, generated solutions or developed improvement plans in accordance with the directions contained in the licensee's policies and procedures. No action had been taken to ensure staff understood and implemented the quality improvement process identified in the licensee's policies and procedures.

ii) The Administrator confirmed that they had taken no action to monitor the implementation of an improvement plan submitted to the Ministry, in response to a continuous quality improvement compliance order served on the licensee on November 23, 2016. The Administrator indicated that they had not monitored the home's progress towards compliance with the previously issued compliance order because it had not been identified as a priority activity.

iii) The Administrator confirmed that they had not provided the Management Company with reports related to quality issues or quality improvement accomplishments and they had not reported that the home was not moving towards compliance for a previously issued compliance order related to quality.

iv) The Licensee confirmed that they may had been copied on some e-mails related to the quality activities in the home, but were not aware of specific initiatives, focuses or activities to improve the quality of care and services in the home.

b) The Licensee, the Management Company and the Administrator failed to implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Process".
This policy identified a quality improvement process that included: selection and/or modification of indicators, audits or projects; set up routine data collection methods for each critical indicator as a Quality Plan; record the monitoring results and provide some analysis; initiate problem solving activities when variations are flagged and subsequently identified as a pattern or trend in the data; evaluate each indicator to determine the usefulness of the indicator and report the results of monitoring activities in a statistical and descriptive format to staff, teams and the Board.
i) Registered staff had been directed to engage in what were identified as quality activities; however, documentation and registered staff completing documentation

related to these quality activities confirmed that specific directions related to the quality process identified in the licensee's policy had not been provided and staff identified they were unsure of the reasons for the activities they had been directed to engage in.

ii) Staff had been provided with as schedule, forms and directions to hold meetings on each resident home area based on identified care areas. A random review of documentation of these meetings for pain, responsive behaviours, skin and wound, restraint reduction and falls care areas confirmed that staff had collected data but had not identified areas for improvement or improvement plans related to the data.

iii) The Nurse Consultant confirmed that the Director of Care (DOC) and Registered Nurses (RN) were to review care audits being completed on each home area. Documentation provided by the home indicated that registered staff # 182 had forwarded an e-mail communication to the DOC and the Nurse Consultant on January 4, 2017, indicating that they had reviewed 20 audits related to "Responsive Behaviours" and identified nine areas where "improvements needed to be made before the home would be in compliance". The Nurse Consultant confirmed that at the time of this inspection there was no documentation to demonstrate that plans had developed or implemented to address the concerns registered staff #182 identified following an analysis of data collected related to the home's compliance with the management of responsive behaviours.

iv) The plan for corrective action developed by the home and submitted to the Ministry following a compliance order, related to continuous quality improvement, served to the home on November 23, 2016, indicated:
- Quality Teams were to meet weekly according to the schedule, keep minutes of the meetings, review quality indicators, benchmark (internal), brain storm, problem solve, identify areas for improvement within each program, implement ideas and evaluate the effectiveness of solutions implemented.
- The RN on each unit was to complete all minutes, track quality indicators and record in the quality module within Point Click Care.
The Nurse Consultant confirmed that the data collected at the meetings noted above had not been analyzed, there was no documentation to substantiate that quality indicators had been identified or tracked and the quality improvement process identified in the licensee's policy had not been followed.

c) The Licensee, the Management Company and the Administrator failed to

implement the licensee's quality improvement and utilization review system when they failed to comply with directions contained in the licensee's policy "Quality Audits".
This policy indicated that standard and routine audits are conducted to ensure that all systems are effective and processes are efficient. Standard audits are conducted minimally of annually and more frequently as outlined in the Audit Schedule. Standardized audits are conducted by members of the interdisciplinary team. The policy identified a number of Administrative Audits, Nursing Service Audits, Recreation and Leisure Audits, Volunteer Service Audits, Dietary Audits, Environmental Services Audits, Accounting Service Audits, Human Resources Audits, Pharmacy Service and Medication Administration Audits and Focused Audits that were to be completed monthly, quarterly, every six months and/or quarterly.

i) The Nurse Consultant confirmed that a Pharmacy Services Audit had not been completed for the 2016 calendar year as was directed in policy, despite the licensee retaining a new Pharmacy Service provider.

ii) The Nurse Consultant indicated that the annual review of the Medication Management System would be documented in the Professional Advisory Meeting minutes. A review of the Professional Advisory Meeting minutes confirmed that a review of the Medication Management system in the home had not been completed for the 2016 calendar year.

iii) The Nurse Consultant confirmed that there was no documentation to indicate that the home had completed an annual review of the Nursing and Personal Support Services staffing plan.

iv) Documentation indicated that data was collected related to the Falls Management Program on December 28, 2016. The documentation indicated that six areas of the review were responded to negatively and five recommendations were made for improvement. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the recommendations made following the data collected on December 28, 2016.

v) Documentation indicated that data was collected related to the Abuse and Neglect Prevention Program during an undated meeting attended by 11 staff. The documentation indicated that 13 areas of the review were responded to negatively. It

was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when recommendations for change had not been made and plans were not developed or implemented based on the negative indicator data collected during this review.

vi) Documentation indicated that data was collected related to the Restraint Reduction Program on December 28, 2016. The documentation indicated that six areas of the review were responded to negatively. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when recommendations for change had not been made and plans had not been developed or implemented based on the negative indicator data collected on December 28, 2016.

vii) Documentation indicated that data was collected related to the Pain Management Program on December 31, 2016. The documentation indicated that seven areas of the review were responded to negatively and five recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the negative indicators and recommendations to improve quality were made on December 31, 2016, during this review.

viii) Documentation indicated that data was collected related to the Behavioural Support Program on December 31, 2016. The documentation indicated that 10 areas of the review were responded to negatively and two recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the negative indicators and recommendations to improve quality made on December 31, 2016, during this review.

ix) Documentation indicated that data was collected related to the Skin and Wound Program on December 31, 2016. The documentation indicated that 10 areas of the review were responded to as negatively and three recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017 that the quality improvement process identified in the licensee's policies

and procedures was not complied with when plans were not developed or implemented based on the negative indicators and recommendations to improve quality made on December 31, 2016 during this review.

xi) Documentation indicated that data was collected related to the Continence Care Program on January 3, 2017. The documentation indicated that nine areas of the review were responded to negatively and seven recommendations for improvement were documented. It was confirmed by the Leadership Team on March 20, 2017, that the quality improvement process identified in the licensee's policies and procedures had not been complied with when plans had not been developed or implemented based on the negative indicators and recommendations to improve quality made on January 3, 2017, during this review.

xii) Seven of the seven annual program reviews identified above were not completed with an interdisciplinary focus as directed in the licensee's policy, two of the above noted annual program reviews were completed by one person and three of the above noted annual program reviews were signed by the Administrator. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 09, 2017

Order # /
Ordre no : 005

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

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 :

1. The licensee shall review and where necessary revise the practices in the home related to the completion of RAI-MDS.

2. The Licensee shall develop a policy and procedure that outlines the practice requirements for the completion on RAI-MDS and provide training related to the practice standards for all staff who have an impact on the completion of RAI-MDS.

3. The licensee shall develop and implement a schedule for the monitoring of compliance with the practice standards and the quality of the processes implemented in the home.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (2), scope (3) and compliance history (2) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the minimal harm/potential for actual harm, the widespread scope of the non-compliance and the licensee's history of non-compliance with the LTCH Act 2017 and the associated Regulations.

2 The licensee failed to comply with the conditions to which the license was subject. The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system. This required each resident's care and services needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the Assessment Reference Date (ARD) of the previous assessment, and any significant change in resident's condition, be reassessed along with Resident Assessment Protocol (RAPs) by the team using the MDS Full Assessment by the 14th day following the determination that a significant change had occurred.
For all other assessments:
a) The care plan must be reviewed by the team and where necessary revised, within 14 days of the ARD or within seven days maximum following the date of the VB2.
b) RAPs must be generated and reviewed and RAP assessment summaries must be

completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the ARD.
The licensee did not comply with the conditions to which the license was subject.

The following residents had incomplete or late Assessment Protocols (APs) completed:

i) An identified resident had an assessment completed with an identified ARD date in June 2016, however AP's related to an identified care area were not completed for 19 days after the ARD date. A second assessment was completed with an identified ARD date in August 2016, however some AP's were not completed for 28 days after the ARD date.

ii) An identified resident had an assessment completed with an identified ARD date in November 2016, however AP's related to an identified care area were not completed for 28 days after the ARD date.

iii) An identified resident had an assessment completed with an identified ARD date in December 2016, however AP's related to an identified care area were not completed for 33 days after the ARD date.

iv) An identified resident had an assessment completed with an identified ARD date in November 2016, however AP's related to an identified care area were not completed for 21 days after the ARD date. A second assessment was completed with an identified ARD date in January 2017, however AP's were not completed for 28 days after the ARD date.

v) An identified resident had an assessment completed with an identified ARD date in December 2016, however AP's related to an identified care area were not completed for 28 days after the ARD date.

vi) An identified resident had a MDS 2.0 Quarterly assessment completed on an identified date in November 2016, and coding on this assessment indicated the resident experienced an identified symptom. Registered staff #183 indicated that for non-triggered clinical conditions staff would document an assessment in the resident's progress notes. Registered staff #283 confirmed that a clinical note had not been documented in the progress notes and that a non-triggered RAP assessment of the identified symptom experienced by the resident had not been

completed.

Registered staff #183 confirmed that a schedule for completing assessments was developed but they do not consistently meet the practice requirements of the RAI-MDS system.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Order # /
Ordre no : 006

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

1. The licensee shall review and were necessary revise the following policies: Medication Errors, The Medication Pass, Administration of Medications and Treatments, Responsive Behaviour Management, Falls Prevention Program, and the Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes.

2. The licensee shall provide training to all staff responsible for complying with the directions contained in the above noted policies. Attendance records are to be maintained related to this training.

3 The licensee will develop and implement a system for monitoring staff's compliance with the directions contained in the above noted policy/procedure documents.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (2), scope (2) and compliance history (5) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm for the identified residents, the scope of pattern of incidents and the licensee's history of non-compliance that included: written notification (WN) issued in March and August 2016 and voluntary plans of corrective action (VPC) issued in February, May, June and November 2016.

The licensee failed to ensure that were 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, procedure, strategy or system, the plan, policy, procedure, strategy or system was complied with.

2. In accordance with O. Reg. 79/10, s. 114(2) the licensee is required to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and disposal of all drugs used in the home.
Staff did not comply with the following licensee's policies that were included in the medication management system:

a) The licensee's "Medication Errors" policy, identified as subsection 8.7 and last reviewed in August 2011 directed that:
- All medication errors would be recorded in the resident's clinical record.
- The resident's physician would be immediately notified.
- The resident's substitute decision maker would be notified.
- All details of the error were to be documented on the progress notes.
- Staff were to complete a Risk Management Report within the computerized documentation system.
- All medication errors will be reviewed by the Pharmacy and Therapeutics Committee who will make recommendations for improvement in the Medication Management System to prevent any further medication errors.

i) Staff did not comply with the above noted policy when a Medication Incident/Near Incident/Adverse Drug Reaction Report confirmed a medication incident involving an identified resident had occurred on an identified date in 2017. Registered staff administered a medication to the resident that was not in accordance with the directions for use specified by the prescriber. The Assistant Director of Care (ADOC) confirmed that a Risk Management Report had not been initiated related to this incident.

ii) Staff did not comply with the above noted policy when a Medication Incident/Near Incident/Adverse Drug Reaction Report confirmed a medication incident involving an identified resident had occurred on and identified date in 2017. Registered staff administered a medication to the resident that was not in accordance with the directions for use specified by the prescriber. A review of the computerized clinical record confirmed that staff had not document the details of this medication incident in the resident's progress notes.

iii) Staff did not comply with the above noted policy when a Medication Incident/Near Incident/Adverse Drug Reaction Report confirmed a medication incident involving an identified resident had occurred on an identified date in 2017. Registered staff failed

to administer a medication to the resident that the resident's physician had ordered the resident to receive. During a review of this incident with registered staff #168 and the ADOC, it was confirmed that there were no records in the resident's clinical record, the Doctor's Book or on the Medication Incident Report that staff had notified the resident's physician of the incident. Registered staff #168 and the ADOC confirmed there were no notations in the resident's clinical record or on the Medication Incident Report that staff had notified the resident's substitute decision maker and staff who discovered the incident had not document the details of the medication incident in the resident's progress notes or complete a Risk Management Report of this incident.

iv) Documentation provided by the home indicated that the Pharmacy and Therapeutics Committee did not review all medication incidents or make recommendations for improvement in the Medication Management System when they met on July 20, 2016, October 18, 2016 or January 18, 2017.

b) The licensee's "The Medication Pass" policy, identified as subsection 8.2 and last reviewed in September 2011 and the licensee's "Administration of Medication/Treatment" policy, identified as subsection 8.2 and last reviewed in September 2011, directed that following the administration of medication to the resident staff were to sign the Electronic Medication Administration Record (EMAR) on the computer screen in the proper space for each medication administered.

Staff did not comply with the above noted policies when it was documented in the identified resident's clinical record that the resident received an identified medication on an identified date, but the registered staff member who administered this medication failed to sign the medication as being given on the EMAR.

c) The licensee's "The Medication Pass" policy identified as subsection 8.2 and last reviewed in September 2011 directed staff to check each medication package and the medication label against the EMAR computer screen for accuracy.

Staff did not comply with the above noted policy when on and identified date in 2017, an identified resident was administered the incorrect medication. Interview notes maintained by the home confirmed that the registered staff member involved in this incident confirmed during an interview that they had not checked the medication label before administering the identified medication to the resident.

3. In accordance with O.Reg. 79/10, s, 53(1) the licensee is required to develop written approaches to care that include protocols and strategies to meet the needs of residents demonstrating responsive behaviours.

The home provided a document titled "Responsive Behaviour Management" identified as 4.11.10 and last revised in March 2011, that contained the protocols and strategies staff were to follow when residents demonstrated responsive behaviour. This documented directed staff to:

a) Report all incidents of responsive behaviours that place the resident or others at risk, including resident to resident abuse immediately to the Ministry of Health and Long Term Care (MOHLTC).

- Staff did not comply with this written strategy when the home submitted a Critical Incident Report (CIR) on and identified date in 2016, which reported that five days earlier an identified resident had demonstrated a responsive behaviour towards a co-resident. This information was reported to MOHLTC five days after the incident had occurred.

- Staff did not comply with this written strategy when the home submitted a CIR on an identified date in 2017, which reported that two days earlier an identified resident had demonstrated a responsive behaviour towards a co-resident. This information was reported to MOHLTC two days after the incident had occurred.

b) The interdisciplinary team will analyze behaviours to identify triggers and consequences of the behaviour, develop therapeutic plans for behaviour management, document in the care plan, implement plan and provide ongoing monitoring and support for the resident as well as continue to monitor behaviour and effects of interventions.

- Staff did not comply with these written strategies related to an identified resident. Registered staff #168 confirmed that an attempt to identify possible triggers for responsive behaviours being demonstrated by the resident had not been made. Clinical documentation confirmed therapeutic plans had not been developed when the resident demonstrated two responsive behaviours. Registered staff #168 and registered staff #183 confirmed there had not been continued monitoring and evaluation of the behaviours being demonstrated by this resident.

- Staff did not comply with these written strategies when registered staff #168 confirmed that an attempt to identify possible triggers for responsive behaviours being demonstrated by an identified resident had not been made and the interdisciplinary team had not met to discuss responsive behaviours being demonstrated by this resident. Clinical documentation confirmed that therapeutic plans had not been developed or implemented when this resident demonstrated two responsive behaviours. Registered staff #168 confirmed there had not been continued monitoring and evaluation of the behaviours being demonstrated by this resident.

4. In accordance with O. Reg. 79/10, s. 30(1) 1, the licensee is required to have an organized program for falls prevention and management that includes relevant policies, procedures and protocols.

The licensee's policy "Falls Prevention Program" identified as subsection 3.6 and last reviewed in June 2015. This policy directed that:

a) The interdisciplinary team will conduct a falls risk assessment.
Registered staff #166 and clinical documentation confirmed staff did not comply with this policy and interdisciplinary falls risk assessments had not been completed for two identified residents.

b) The Charge Nurse/Unit Manager is responsible for coordinating monthly (currently being held weekly) meetings with members of the care team, including registered nursing staff, PSW staff, Restorative staff, physiotherapy staff, dietary staff, activity and environmental staff.
Staff did not comply with this policy when staff on three resident home areas confirmed that staff attending the meetings were Registered Practical Nurses (RPN), PSW staff and no other members of the interdisciplinary team attended the meetings. Registered staff #612 confirmed that only staff working in the nursing department attended the meetings.

c) The team reviews all falls incidents, including medical history, drug record, the resident's care plan and the Post Fall Incident Investigative Tool.
The DOC confirmed staff did not comply with this policy when documentation of Falls Prevention Meetings held on three resident home areas did not include evidence that the above noted factors were considered when reviewing fall incidents.

d) Resident care plan is reviewed and recommendation for safety are made by the team and included in the resident's care plan.
The DOC confirmed staff did not comply with this policy when minutes of these meetings held on three consecutive months in 2017, identify four residents who had fallen, however there were no recommendation made for changes to the resident's care plan identified or documented in record of the meetings.

5. In accordance with the LTCH Act 2007, c. 8, s. 21 the licensee is require to ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and how the licensee deals with complaints.

The licensee failed to ensure that staff complied with the licensee's policy "Process for Obtaining Information, Raising Concerns, Lodging Complaints or Recommending Changes", identified as section 4.2, subsection 4.2.10 and last reviewed in March 2016, when they failed to comply with the following directions:

a) The Administrator (or designate) shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

i) Staff did not comply with this direction when the ADOC confirmed that there was not a record created following a complaint by a Personal Support Worker (PSW) that an identified resident had not been provided with care over what was identified as an extended period of time. This incident was reported to MOHLTC via a Critical Incident Report (CIR) under the category of neglect.

ii) Staff did not comply with this direction when the ADOC confirmed that there was not a record created following a complaint that an identified resident had sustained an injury while care was being provided.

b) The Administrator shall provide a written report to the Ministry of Health and Long

Term Care using the Critical Incident Report within 10 business days of the incident that is to include a description of the incident, individuals involved, actions taken in response to the incident, the outcome or current status of the individuals who were involved in the incident, the analysis and follow-up actions, immediate actions that have been taken to prevent a recurrence and the long term plan to correct the situation.

Staff did not comply with this direction when it was reported on an identified date that an identified resident had sustained an injury while care was being provided. The ADOC, Nurse Consultant and documentation confirmed that a written report was not provided to the MOHLTC for 23 days after the incident.

c) The Administrator (or designate) shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes: the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action taken, time frames for action to be taken and any follow-up action required; final resolution, if any; every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant.

Staff did not comply with this direction when a document provided by the home identified as "Bella Senior Care Residence Complaint Log 2017" containing 32 identified complaints between January 1, 2017 and March 19, 2017, did not contain the following information about the items listed on the log:
-the type of action taken to resolve the complaint, including the date of the action taken, time frames for actions taken and any follow up action required
- the final resolution, if any, to the concerns identified
-a description of the response made to the complainant
-any response made in turn by the complaint.

6. In accordance with O. Reg. 79/10, s. 30(1)1 the licensee is required to ensure that written policies and protocols are developed for the organized program of Nursing and Personal Care identified in section 8 of the Act.

Staff did not comply with the following policy that was included in the organized program of Nursing and Personal Care.

The licensee's "Safe Handling and Assessing Residents" policy, identified as subsection 4.6.1.d last revised in June 2013, directed that the procedure for turning a resident in bed was that staff were to cross the resident's arms over their chest and then roll the resident gently in the direction required.

Staff did not comply with this policy when on an identified date, a PSW was observed by another staff member to use unsafe positioning techniques when assisting an identified resident. The DOC confirmed that the positioning technique used by the PSW was not safe and not as is directed in the home's Safe Handling and Assessing Residents policy.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Order # /
Ordre no : 007

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

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 :

1. The licensee shall review and were necessary revise the policy/procedure "Safe Handling of Residents".

2. The licensee will provide education and training to all staff involved in the transfer and positioning of residents. Attendance records are to be maintained related to this training.

3. All residents who require assistance with transfers and positioning are to be reassessed and the plan of care reviewed/revised to ensure the plans of care for those resident provide resident specific details of the methods to be used for transferring and positioning.

4. The licensee will develop and implement a system for monitoring staff's performance in complying with directions identified in residents plans of care for transferring and positioning.

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

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (3), scope (2) and compliance history (4) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the actual harm that identified residents experienced, the scope of pattern of incidents and the licensee's history of non-compliance that included issuance of Compliance Orders (CO) in March 2015 and July 2016.

2. Staff did not use safe transferring and positioning techniques when on an identified date in 2016 an identified resident was transferred which resulted in the resident sustaining an injury. Personal Support Worker (PSW) #604 and #605 confirmed that on the identified date that they did not safely position and transfer the resident which resulted in the resident falling and sustaining an injury.

3. Staff did not use safe positioning techniques when on an identified date in 2017, PSW #171 used an unsafe positioning technique to reposition an identified resident which resulted in the resident sustaining an injury. The DOC confirmed that the positioning technique used by PSW #171 was not a safe positioning technique and was inconsistent with the directions contained in the home's Safe Handling and Assessing Residents policy.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Ontario

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 des Soins de longue durée

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 : 008

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

1. The licensee shall reassess all residents, including resident #009 and resident #010, who demonstrate responsive behaviours that have the potential to result in potentially harmful interactions between and among residents.

2. For all residents noted above behavioural triggers are to be identified, where possible, and interventions designed to reduce the risk of harmful interactions between residents are to be included in each residents plan of care and implemented.

3. The licensee is to develop and implement a regular schedule monitoring the effectiveness of the interventions implemented to reduce the risk of harmful interactions between residents.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (3), scope (3) and compliance history (3) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of actual harm to one resident reviewed, the scope of a pattern of incidents and the licensee's history of non-compliance related to the management of responsive behaviours including two Written Notifications in May 2015 and March 2016, two Voluntary Plans of Correction in May 2016 and August 2016 and a Compliance Order in May 2016 non-compliance with regulations related to the management of responsive behaviours.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

2. Staff did not use safe transferring and positioning techniques when on an identified date in 2016 an identified resident was transferred which resulted in the resident sustaining an injury. Personal Support Worker (PSW) #604 and #605 confirmed that on the identified date that they did not safely position and transfer the resident which resulted in the resident falling and sustaining an injury.

3. Staff did not use safe positioning techniques when on an identified date in 2017, PSW #171 used an unsafe positioning technique to reposition an identified resident which resulted in the resident sustaining an injury. The DOC confirmed that the positioning technique used by PSW #171 was not a safe positioning technique and was inconsistent with the directions contained in the home's Safe Handling and Assessing Residents policy.

(129)

Ontario

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Order # /
Ordre no : 009

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

1. The licensee shall revise the policies and procedures that make up the program for the management of responsive behaviours to include a method for documenting responsive behaviours that will allow behavioural data to be collected and analyzed.

2. The licensee is to provide training to all staff who provide direct care to residents related to the policies, processes and practices identified in the program for the management of responsive behaviours. Attendance records for this training are to be maintained.

3. The licensee shall reassess all residents who demonstrate responsive behaviours, review and revise each resident's plan of care to ensure identified triggers for the behaviours, reasonable goals of care have been identified and resident specific care interventions are in place to manage behaviours being demonstrated.

4. The licensee will develop and implement a system for monitoring staff's performance in complying with the policies and procedures as well as track the success of the effectiveness in managing responsive behaviours.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (3), scope (2) and compliance history (4) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of actual harm to one resident reviewed, the scope of a pattern of incidents and the licensee's history of non-compliance which included two Written Notifications issued in May 2015 and March 2016, two Voluntary Plans of Correction issued in May 2016 and August 2016 and one Compliance Order issued in May 2016.

The licensee failed to ensure that for each resident demonstrating responsive behaviours that behavioural triggers for the resident were identified, where possible; strategies were developed and implemented to respond to the behaviours, where possible and actions were taken to respond to the needs of the resident, including assessments and reassessments.

2. An identified resident's clinical record confirmed that the resident demonstrated three responsive behaviours towards staff and co-residents.
i) Registered staff #182 and clinical documentation confirmed that staff in the home

did not utilize a behaviour tracking mechanism that would allow staff to collect data in order to identify possible triggers for responsive behaviour and there had been no attempt to identify triggers for the responsive behaviours demonstrated by this resident.

ii) Registered staff #182 and clinical documentation confirmed that strategies had not been developed or implemented to respond to responsive behaviours being demonstrated by this resident.

3. An identified resident's clinical record confirmed that the resident demonstrated a responsive behaviour towards a co-resident on an identified date in 2016 and then again six days later. The clinical record confirmed that there was no documentation in the resident's plan of care to indicate that strategies had been developed or implemented to manage this responsive behaviour demonstrated towards this co-residents.

4. Staff providing care to an identified resident indicated that the resident demonstrated a second responsive behaviour related to care. The clinical record confirmed there was no documentation in the resident's plan of care to indicate that strategies had been developed or implemented to ensure that care plan directions were followed and the resident received the care specified in the plan of care.

5. The clinical record confirmed that the identified resident demonstrated a third responsive behaviour related to the implementation of a medical regime. A review of the clinical record confirmed that the resident demonstrated this behaviour during an identified month in 2016. The clinical record confirmed there was no documentation in the resident's plan of care to indicate that strategies had been developed or implemented to manage the responsive behaviour demonstrated by this resident related to the implementation of a medical regime.

6. Registered staff #177 confirmed that actions had not been taken to assess and reassess an identified resident in relation to the ongoing demonstration of responsive behaviours.
Registered staff #182 and clinical documentation confirmed that the resident's plan of care related to responsive behaviours identified a reassessment period of three months and that the staff had not reassess the resident's responsive behaviours at any time other than the scheduled quarterly Resident Assessment Instrument-Minimum Data Set (RAI-MDS) mandatory assessments. Registered staff #177 and

clinical documentation confirmed that when two consecutive RAI-MDS mandatory assessments were completed for this resident, a reassessment of the behaviours being demonstrated by the resident had not been undertaken, an evaluation of the effectiveness of care being provided related to the responsive behaviours had not been undertaken and there were no changes to the resident's plan of care related to three responsive behaviours demonstrated by this resident.

7. Registered staff #182 and clinical documentation confirmed that staff providing care to an identified resident were aware of four responsive behaviours being demonstrated by the resident. Registered staff #182 confirmed that the home did not utilize a process for the identification of potential behavioural triggers and although the resident's plan of care included the above noted responsive behaviours staff had not attempted to identify triggers for the behaviours being demonstrated by this resident.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Ontario

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 : 010

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

1. The licensee is to complete a review of the Medication Management System that includes the processes used in the home for the administration of medications and the management of controlled substances.

2. The licensee is to complete a review of the medication incident reports documented since January 1, 2017. The review is to include an analysis of factors contributing to the incidents reviewed and the development and implementation of strategies to prevent further medication incidents.

3. The licensee is to provide education and training for all staff involved in the administration of medications related to the process of medication administration, actions to take when a resident refuses to take medications as specified by the prescriber and the responsibilities related to the monitoring of controlled substances.

4. The licensee is to develop and implement a monitoring system related to staff's performance in the administration of medications and the management of controlled substances.

Grounds / Motifs :

1. This Order is based on the application of the factors of severity (2), scope (3) and compliance history (3) in keeping with O. Reg. 79/10, s. 299. This is in respect to the severity of the potential for actual harm to four residents, the widespread scope of the non-compliance and the licensee's history of non-compliance that included two Voluntary Plans of Correction identified in July 2016 and November 2016.

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) An identified resident was administered a drug that was not in accordance with the directions for use specified by the prescriber. The Assistant Director of Care (ADOC), clinical documentation, records maintained by the home and a Critical Incident Report (CIR) submitted to the Ministry of Health and Long Term Care (MOHLTC) confirmed the resident' physician had ordered the resident to receive an identified drug at a specific time. The above noted documents confirmed that on an identified date in 2017, a registered staff member administered a different drug that was not prescribed to be given to the resident at that time. The registered staff member immediately recognized the situation and took action related to this in incident. (PLEASE NOTE: The above noted non-compliance while completing an inspection of Critical Incident Inspection # 002773-17)

b) An identified resident was administered a drug that was not in accordance with the directions for use specified by the prescriber. Registered staff #167, clinical documentation and a Medication Incident Report provided by the home confirmed that the resident's physician had ordered the resident to receive an identified drug twice daily. The Medication Administration Record (MAR) indicated that the scheduled times for the administration of this drug were 0800 hours (hrs.) and 2000 hrs. Registered staff worked during the day on an identified date in 2017, administered the medication as ordered at 0800hrs and administered the medication again at 1900 hours. The Registered staff who administered the medication at 1900hrs did not document the administration of this medication in the resident's Medication Administration Record (MAR). Registered staff #167 confirmed that on the identified date, they administered the 2000hrs dose of this medication because they were unaware that the registered staff working days had administered the 2000hrs dose of the medication at 1900hrs. Registered staff #167 and pharmacy records provided by the home confirmed that the resident received this medication at 0800hrs, 1900hrs and 2000hrs instead of the two times a day this medication was ordered to be administered.

c) An identified resident was administered a drug that was not in accordance with the directions for use specified by the prescriber. The ADOC, clinical documentation and a Medication Incident Report provided by the home confirmed that the resident's physician had ordered the resident to receive an identified drug twice a day and the

MAR identified that this medication was to be administered at 0800hrs and at 1700hrs. The MAR and other records maintained in relation to drug administration confirmed that on an identified date in 2017 the resident received this medication in the required dose at 0756hrs and did not receive the second scheduled dose of this medication as was prescribed by the resident's physician.

d) An identified resident's physician ordered the resident to receive an identified drug. The clinical record confirmed that the above noted order was written in 2016, and was a current active order at the time of this inspection.
i) On an identified date in 2016, registered staff documented in the clinical record that they were unable to confirm that the resident received the drug as ordered by the residence's physician.
ii) A day following the above noted incident registered staff documented in the clinical record that they were unable to confirm that the resident received the drug as ordered by the resident's physician.
iii) Eleven days following the above note incident registered staff documented in the clinical record that they were unable to confirm that the resident received the drug as ordered by the resident's physician.
On the above three noted occasions staff did not ensure that a drug was administered to the identified resident as specified by the resident's physician.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jul 14, 2017(A1)

Ontario

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 des Soins de longue durée

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

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

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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.

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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.

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 11 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK - (A1)

Service Area Office /
Bureau régional de services : Hamilton