Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 2, 2018	2018_569508_0005	010932-17, 028239-17	Critical Incident System

Licensee/Titulaire de permis

Bella Senior Care Residences Inc.
650 Sheppard Avenue East PH01 TORONTO ON M2K 3E4

Long-Term Care Home/Foyer de soins de longue durée

Bella Senior Care Residences
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

ROSEANNE WESTERN (508), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 8, 9, 12, 13, 14, 15, 16, 21, 22 and 23, 2018.

During the course of the inspection, the inspectors toured the home, reviewed resident clinical records, reviewed the home's internal investigative notes and observed provision of care.

PLEASE NOTE This inspection was conducted concurrently with with following inspections: complaint inspection # 2018_569508_0006, follow up inspection # 2018_569508_0004 and the following inquiries: Log # 027961-17 pertaining to alleged improper care of a resident, log # 027075-17 and log # 029757-17 pertaining to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), registered staff and Personal Care Providers (PCP).

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

In accordance with the Long-Term Care Homes Act, 2007, Ontario Regulation 79/10, s. 2 (1) verbal abuse is defined as: any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well- being, dignity or self-worth, that is made by anyone.

According to Critical Incident System (CIS) report # 2890-000022-17, on an identified date in 2017, resident #004 was having care provided to them by two PCP's. During care, PCP #155 pointed to the resident and made a comment, which according to PCP #204 who witnessed the incident confirmed that the resident then became agitated and was upset and yelled at PCP #155. During a review of the home's internal Investigative notes and interview with the Administrator on February 12, 2018, it was confirmed that the resident was not protected from verbal abuse.

This area of non-compliance will be issued as a WN as this incident occurred prior to the compliance order that was issued on September 14, 2017, report #2890-000022-17, where the licensee failed to ensure that residents were protected from abuse by anyone. [s. 19. (1)]

Issued on this 9th day of March, 2018

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

Original report signed by the inspector.