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


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 16, 2018 | 2018_569508_0006 | 015115-17, 023302-17, 002342-18 | Complaint |

### 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 Complaint 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, complaint log, relevant policies and procedures and observed provision of care. The following complaint intakes were completed during this inspection: log #015115-17 pertaining to accommodation charges, #023302-17 pertaining to numerous care concerns and #002342-18 pertaining to unexplained injury to a resident.**
**This inspection was conducted concurrently with Critical Incident System report inspection #2018_569508_0005 and Follow-up Inspection #2018_569508_0005. Non-compliance related to O. Reg. s. 8(1)(b) was identified related to a complaint, log #023302-17, and issued on Follow-up Inspection report #2018_569508_0005.**

**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), residents and family members.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Medication**
**Personal Support Services**
**Responsive Behaviours**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

The home had purchased a specific device for bathing the resident. The ADOC confirmed that the specific device was purchased for this resident. Review of the resident's plan of care and kardex did not include the use of this device prior to the resident sustaining an injury on an identified date in 2018. The ADOC confirmed in January 2018, that resident #020's written plan of care should have included the use of this device. [s. 6. (1) (a)]

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

i. Resident #020's plan of care directed staff that when the resident was being showered that there were to be two staff present at all times. On an identified date in 2018, resident #020 was receiving their shower by PCP #174 and #148 and the resident sustained a superficial injury to an identified area on their body. A review of the home's investigative notes confirmed that PCP #174 had to leave the spa room to answer call bells, leaving the other PCP alone with the resident. During this time PCP #148 noted that the resident had shifted while on a specific device and sustained a superficial injury. The Administrator confirmed in February 2018, that the staff did not follow the resident's plan of care and ensure that the resident was showered by two people for the entire process.

ii. Resident #020's plan of care directed staff that the resident was not to be bathed at a specific time of day. On an identified date in 2018, resident #020 was bathed at this time by PCP #174 and #148. The Administrator confirmed in February 2018, that the staff did not follow the resident's plan of care regarding bathing times.

iii. Resident #021's plan of care stated that the resident was part of a specified program and this should have been identified outside the resident's room in their memory box and on their mobility device. An observation of the resident's room in February 2018 identified that the program was identified in their memory box, not on the resident's mobility device. RPN # 246 confirmed that the program should have been on the resident's mobility device and confirmed that the care set out in the plan was not provided to the resident as specified in the resident's plan of care.

This finding of non compliance was identified during Critical Incident Inspection 2890-000039-17.

iv. Resident #021's plan of care directed that when the resident was in bed their call bell was to be attached in a specific way and to be within reach at all times. In February 2018, resident #021 was observed by the LTC Homes Inspector in bed and their call bell was not attached as their plan had directed and the resident was looking for their call bell and could not find it. Interview with RPN #254 confirmed that the plan of care did direct staff that the call bell was to be attached in a specific way and to be within reach at all times and that the staff did not follow the resident's plan of care and ensure the resident had their call bell in reach at all times.

This finding of non compliance was identified during Critical Incident Inspection 2890-000039-17. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, that the care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Bella Senior Care Residence is a long term care home with a licensed capacity of 160 beds. The planned staffing pattern for RNs in the home, for direct care of residents, is two RNs on the day shift and one RN on the night shift. The RNs work 12 hour shifts. The home also utilizes a mix of RPNs and personal support workers to meet the nursing and personal care needs of residents.

Interview with the DOC identified that the home does have a sufficient number of RNs on staff to fill all of the required shifts in the staffing plan; however, occasionally due to illness there are times when the home has vacant shifts which need to be filled.

It was identified that the home consistently offers additional shifts to regular RNs to fill these vacant shifts and offers overtime. However, when the RNs employed by the home are unwilling or unable to work the vacant shifts the home may fill the required shifts with RNs employed with an employment agency, to ensure that there is an RN onsite 24 hours a day seven days a week.

On request, the DOC provided a list of the shifts worked by agency RNs, when they were the only RN in the building from September, 2017 to February, 2018.

It was identified that there were a total of three shifts when the home had only one RN in the building, an agency RN, who was not a member of the regular nursing staff.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least one registered nurse who is an employee of the licensee and is a member or the regular nursing staff on duty and is present at all times, to be implemented voluntarily.***

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**Issued on this 20th day of April, 2018**

**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**

**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

**Ministére 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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ROSEANNE WESTERN (508), LESLEY EDWARDS (506) |
| **Inspection No. / No de l'inspection :** | 2018_569508_0006 |
| **Log No. / No de registre :** | 015115-17, 023302-17, 002342-18 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Apr 16, 2018 |
| **Licensee / Titulaire de permis :** | Bella Senior Care Residences Inc.<br>650 Sheppard Avenue East, PH01, TORONTO, ON, M2K-3E4 |
| **LTC Home / Foyer de SLD :** | Bella Senior Care Residences<br>8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Kerry Abbott |

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.O. 2007, c.8, 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 :**

The licensee must be compliant with s. 6(7) of the LTCHA.

Specifically the licensee must:

1. Review the plans of care of residents #020 and #021, and all residents to ensure that the plan of care interventions related to the level of assistance for bathing, bathing equipment and falls interventions to ensure they meet the current needs of the resident.

2. Ensure Personal Care Providers (PCP), staff #148 and #174 review the plan of care of resident #020 related to bathing instructions to ensure that the resident is provided care as specified in their plan of care. This review should be documented.

3. Review resident #021's plan of care related to fall prevention with PCP staff on the home area by reviewing the resident's interventions at change of shift for a seven day period. This review should be documented.

**Grounds / Motifs :**

1. The licensee failed to ensure that the care set out in the plan of care was provided to residents #020 and #021 as specified in their plan.

i. Resident #020's plan of care directed staff that when the resident was being showered that there were to be two staff present at all times. On an identified date in 2018, resident #020 was receiving their shower by PCP #174 and #148 and the resident sustained a superficial injury to an identified area on their body. A review of the home's investigative notes confirmed that PCP #174 had to

leave the spa room to answer call bells, leaving the other PCP alone with the resident. During this time PCP #148 noted that the resident had shifted while on a specific device and sustained a superficial injury. The Administrator confirmed in February 2018, that the staff did not follow the resident's plan of care and ensure that the resident was showered by two people for the entire process.

ii. Resident #020's plan of care directed staff that the resident was not to be bathed at a specific time of day. On an identified date in 2018, resident #020 was bathed at this time by PCP #174 and #148. The Administrator confirmed in February 2018, that the staff did not follow the resident's plan of care regarding bathing times.

iii. Resident #021's plan of care stated that the resident was part of a specific program and this should have been identified outside the resident's room in their memory box and on their mobility device. An observation of the resident's room in February 2018 identified that the program was identified in their memory box, not on the resident's mobility device. RPN # 246 confirmed that the program should have been on the resident's mobility device and confirmed that the care set out in the plan was not provided to the resident as specified in the resident's plan of care.

This finding of non compliance was identified during Critical Incident Inspection 2890-000039-17.

iv. Resident #021's plan of care directed that when the resident was in bed their call bell was to be attached in a specific way and to be within reach at all times. In February 2018, resident #021 was observed by the LTC Homes Inspector in bed and their call bell was not attached as their plan had directed and the resident was looking for their call bell and could not find it. Interview with RPN #254 confirmed that the plan of care did direct staff that the call bell was to be attached in a specific way and to be within reach at all times and that the staff did not follow the resident's plan of care and ensure the resident had their call bell in reach at all times.

This finding of non compliance was identified during Critical Incident Inspection 2890-000039-17. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two of

three residents reviewed. The home had a level 5 history as the home had multiple non-compliances with at least one related to the area of this concern with this section of the LTCHA that included:

voluntary plan of correction (VPC) issued March 2016 (2016_250511_0005);
VPC issued May 2016 (2016_247508_0008);
compliance order (CO), director review (DR) issued July 2016with a compliance due date of January 2017 (2016_250511_0011);
VPC issued August 2016 (2016_248214_0019);
VPC issued September 2016 (2016_250511-0012);
WN issued November 2016 (2016_542511_0017);
VPC issued November 2016 (2016_542511_0018);
WN issued January 2017 (2017_569508_0001);
CO issued in February 2017 with a compliance date of July 14, 2017 (2017_587129_0002);
VPC/DR issued in May 2017 (2017_555506_0012);

(506)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** May 31, 2018

## 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  16th  day of April, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Ministére 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

**Name of Inspector / Nom de l'inspecteur :** Roseanne Western

**Service Area Office / Bureau régional de services :** Hamilton Service Area Office