Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2019	2019_569508_0029	015349-19, 016990-19, 019439-19	Critical Incident System

Licensee/Titulaire de permis

Chippawa Creek Care Centre Ltd.
c/o Park Place Seniors Living Inc. 20 Adelaide Street East, Suite 303 TORONTO ON M5C 2T6

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)

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): October 18, 22, 23, 24, 2019.

The following intakes were inspected during this Critical Incident System inspection:

- Log # 015349-19, related to responsive behaviours;
- Log # 016990-19, related to falls prevention and management;
- Log # 019439-19, related to falls prevention and management;

Please note: This inspection was conducted concurrently with a complaint inspection #2019_569508_0028.

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures and staff training records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (DOC), the Assistant Director of Care (ADOC), Behavioural Support of Ontario (BSO) Team Lead, Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Care Providers (PCP)s and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident was being reassessed and the plan of care revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A Critical Incident (CI) report was submitted to the Director on an identified date in 2019 related to a resident's fall that resulted in an injury.
A review of the resident's clinical records indicated that the resident had cognitive impairment and was identified as a high risk for falls.

On an identified date, resident #002 was found by staff on the floor as the resident had fallen. It was identified during the post fall assessment that resident #002 had self transferred and fell. Upon initial post fall assessment, it was determined that the resident had not sustained an injury.

The resident was monitored at the home until the following day when the resident started exhibiting symptoms of pain and injury to an identified area of their body. The resident was transferred to hospital for further investigation and returned back to the home. It was confirmed that the resident sustained a significant injury to the affected area.

During a review of the resident's clinical records over an identified period, it was identified that the resident continued to fall multiple times under the same circumstances. Several "near misses' were also documented where staff were able to intervene and prevent the resident from falling; however, this intervention was not included in resident's plan of care to minimize their risk of falls.

On an identified date after the resident had the fall with significant injury, registered staff #109 documented that the resident's care plan was reviewed and was current. No new

interventions were implemented. The following morning, resident #002 had fallen again.

A review of the resident's current plan of care indicated that although interventions had been implemented, the interventions were ineffective for resident #002 and the resident continued to fall. During interview with the Acting DOC, it was identified that not all other approaches had been considered.

It was confirmed during record reviews and during interview with the Acting DOC that when the plan of care was being revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate instrument specifically designed for this purpose.

A review of the resident's clinical records indicated that the resident had cognitive impairment and was identified as a risk for falls. On an identified date in 2019, resident #002 had a fall, was transferred to hospital where it was confirmed they had an identified injury.

The resident was transferred back to the home with a specific intervention in place. The

following day the resident was assessed and it was identified that the resident had pain in the affected area.

According to the home's Pain Management Policy, due to the resident's cognitive impairment, a Pain Assessment in Advance Dementia (PAINAD) should have been conducted; however, a numerical pain assessment was conducted instead.

On an identified date, progress notes indicated that the resident had pain and was given routine analgesics. No pain assessment was conducted.
The following day, progress notes indicated that the resident screamed during palpation of the affected area. No pain assessment was conducted. Routine analgesics were administered. It was undetermined if the pain medication was effective as no documentation or a pain assessment had been completed.

Several days later, the resident had another fall. The resident's pain was again assessed with the numerical pain assessment. It was also noted during a post fall assessment that the resident sustained new injuries.

Three days later, the resident was transferred to hospital due to complications and was admitted for an identified period.
The resident was re-admitted back to the home. During review of the resident's clinical records, it was identified that the resident experienced episodes of pain due to their injury.

Further review indicated that the pain assessments conducted were not always conducted using a clinically appropriate assessment instrument for a resident with their level of cognitive impairment and on two identified dates where the resident had pain, no pain assessments were completed.

It was confirmed during review of the documentation and during interview with the Acting DOC that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 when the resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: 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 has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by implementing interventions.

A Critical Incident (CI) report was submitted to the Director on an identified date in 2019, reporting that an altercation occurred between two residents. Review of the clinical record for resident #004 indicated that resident #004 had been identified as having responsive behaviours and a history of non-triggered aggressive behaviour towards co-residents and staff.

Progress notes and the CI report indicated that on an identified date in 2019, resident #004 was aggressive towards resident #005. When the PCP attempted to intervene, resident #004 threatened the staff.

Resident #004 then attempted to enter other co-resident's rooms and picked up an object and threatened to hit staff with them. Staff were able to intervene to prevent further altercations.

Resident #005's care plan was revised to include a specific intervention to minimize the risk of resident #004 entering their room again.

During an observation of both residents, it was identified that the intervention in resident #005's plan of care was not implemented. The inspector asked Registered Practical Nurse (RPN) #104 where this intervention was and they indicated that it had been implemented; however, resident #005 had a history of removing it.

The inspector and the RPN searched the resident's room and this intervention could not be located.

It was confirmed during this observation and during interview with RPN #104 that steps taken to minimize the risk of altercations and potentially harmful interactions between residents had not been implemented during this observation. [s. 54. (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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions by implementing interventions, to be implemented voluntarily.

Issued on this 22nd day of November, 2019

[redacted]

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

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

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)
Inspection No. / No de l'inspection :	2019_569508_0029
Log No. / No de registre :	015349-19, 016990-19, 019439-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 4, 2019
Licensee / Titulaire de permis :	Chippawa Creek Care Centre Ltd. c/o Park Place Seniors Living Inc., 20 Adelaide Street East, Suite 303, TORONTO, ON, M5C-2T6
LTC Home / Foyer de SLD :	Bella Senior Care Residences 8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Veronica Swartz

To Chippawa Creek Care Centre Ltd., 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s. 6(11)(b) of the LTCH Act.

Specifically, the licensee must:

1. Reassess the plan of care for resident #002 and any other resident identified as a high risk for falls and consider different approaches to minimize the resident's risk of falls and/or injury.

2. Develop and implement an auditing system to ensure that when the post fall assessments are being completed, the plan of care is being reviewed and residents are assessed for different interventions to reduce the risk for falls, where necessary.

3. Ensure this information is documented in the resident's clinical record.

Grounds / Motifs :

1. 1. The licensee failed to ensure that when the resident was being reassessed and the plan of care revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A Critical Incident (CI) report was submitted to the Director on an identified date

in 2019 related to a resident's fall that resulted in an injury.

A review of the resident's clinical records indicated that the resident had cognitive impairment and was identified as a high risk for falls.

On an identified date, resident #002 was found by staff on the floor as the resident had fallen. It was identified during the post fall assessment that resident #002 had self transferred and fell. Upon initial post fall assessment, it was determined that the resident had not sustained an injury.

The resident was monitored at the home until the following day when the resident started exhibiting symptoms of pain and injury to an identified area of their body. The resident was transferred to hospital for further investigation and returned back to the home. It was confirmed that the resident sustained a significant injury to the affected area.

During a review of the resident's clinical records over an identified period, it was identified that the resident continued to fall multiple times under the same circumstances. Several "near misses' were also documented where staff were able to intervene and prevent the resident from falling; however, this intervention was not included in resident's plan of care to minimize their risk of falls.

On an identified date after the resident had the fall with significant injury, registered staff #109 documented that the resident's care plan was reviewed and was current. No new interventions were implemented. The following morning, resident #002 had fallen again.

A review of the resident's current plan of care indicated that although interventions had been implemented, the interventions were ineffective for resident #002 and the resident continued to fall. During interview with the Acting DOC, it was identified that not all other approaches had been considered.

It was confirmed during record reviews and during interview with the Acting DOC that when the plan of care was being revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

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 1 as it was related to 1 out of 3 residents. The home had a level 3 history of one or more non-compliance(s) in the same subsection. (508)

(508)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2019

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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 4th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

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

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