Hamilton District
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Original Public Report

Report Issue Date: May 4, 2023	
Inspection Number: 2023-1375-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Chippawa Creek Care Centre Ltd.	
Long Term Care Home and City: Bella Senior Care Residences, Niagara Falls	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 13, 17-21, 24, and 25, 2023.

The following intakes were inspected in this complaint inspection:

- Intake: #00022378 related to personal care and alleged neglect.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00003365 [CI: 2890-000022-21] related to an unexpected death.
- Intake: #00007829 [CI: 2890-000025-22] related to falls prevention and management.

The following intakes were completed in this inspection: intake #00002881, CI 2890-000019-22; intake #00002969, CI 2890-000007-22; intake #00003518, CI 2890-000024-22; intake #00004730, CI 2890-000012-22; intake #00005275, CI 2890-000021-21; intake #00006347, CI 2890-000004-22; and intake #00007134, CI 2890-000010-22 were related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the care as set out in the plan was no longer necessary, specifically related to fall prevention equipment.

Rationale and Summary
A resident's care plan was updated to include specific fall prevention equipment.

The resident was observed without the falls prevention equipment, which the resident confirmed.

A personal care provider (PCP) confirmed that the resident did not have that fall prevention equipment as it was no longer necessary. They also said that the resident’s care plan needed to be updated. The unit's registered practical nurse (RPN) revised the care plan the same day, removing the fall prevention equipment.

Sources: Resident's clinical records; observations; interviews with the resident and staff.
Date remedied: April 17, 2023
[720920]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the fall prevention and management program, as required in Ontario Regulations (O. Reg.) 246/22 s. 53 (1) 1, including interventions, were documented for a resident.

Rationale and Summary
A resident was deemed high risk for falls and had several fall prevention interventions detailed in their care plan including fall prevention equipment. Both an RPN and PCP stated that the PCPs would check that the equipment was in place on an hourly basis and sign off on flow sheets kept in a binder at the nursing station.

A review of flow sheets for August to October 2022 and April 2023, identified that several entries were not completed as required. For each shift, staff were required to check and sign off on the two different fall prevention equipment eight times.

Documentation was not completed for the one of the fall prevention equipment for two shifts in August, 16 shifts in September, 19 shifts in October, 2022, and six shifts in April 2023.

Documentation was not completed for the other fall prevention equipment for two shifts in August, 15 shifts in September, 19 shifts in October, 2022, and six shifts in April 2023.

The Director of Care (DOC) acknowledged that the flow sheets were part of the home's fall prevention and management program and expected staff to complete the documentation on the flow sheets.

Failure to document fall prevention interventions may have resulted in care not being provided as per the resident's needs.

Sources: Resident's clinical records; interviews with the DOC and other staff. [720920]

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with monitoring of two residents after unwitnessed falls.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a fall prevention and management program that provides strategies to mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the policy "Falls Prevention and Management Program", dated January 2022 and 2023, which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary
The home's Fall Prevention and Management Program required registered staff to monitor residents after an unwitnessed fall using the clinical monitoring records which required documenting on neuro-vital signs, vital signs, pain and behaviour changes. The monitoring was to occur initially after the fall, every hour for the first four hours and then every eight hours for 72 hours.

A registered nurse (RN) and RPN stated that after an unwitnessed fall they were to complete clinical monitoring records in point click care (PCC). The RN explained that they used the home's fall worksheet as an auditing tool and a reminder of the timing; however, the information on the worksheet needed to be entered into the clinical monitoring records in PCC. They also said that the completed worksheets were sent to the DOC for filing and not placed in the resident's chart. A review of the home's fall worksheets showed that registered staff would only document vital signs, but not additional monitoring as required by the policy.

A. A resident had an unwitnessed fall. A review of the clinical monitoring records in PCC showed that clinical monitoring records were not completed three times during the 72-hour monitoring period.

B. Another resident had three unwitnessed falls. Six clinical monitoring records were not created in PCC for the first fall, three for the second fall and eight for the third fall.

The DOC acknowledged that registered staff were expected to complete the clinical monitoring records in PCC as they contained additional information required for monitoring residents post unwitnessed falls beyond vitals.

Failure to complete the clinical monitoring records as required may have resulted in staff not identifying complications after an unwitnessed fall, if the resident had sustained a head injury.

Sources: Residents' clinical records, Fall Prevention and Management Program (RC-15-01-02, January 2022 and 2023); interviews with DOC and other staff. [720920]