Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: September 6, 2023	
Inspection Number: 2023-1375-0003	
Inspection Type: Critical Incident	
Licensee: Chippawa Creek Care Centre Ltd.	
Long Term Care Home and City: Bella Senior Care Residences, Niagara Falls	
Lead Inspector Cathy Fediash (214)	**Inspector Digital Signature** Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2023.09.07 09:14:51 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 18, 21-25, 28-31, and September 5, 2023.

The following intake(s) were inspected:

- Intake: #00001098 - Critical Incident (CI) #2890-000017-22, related to prevention of abuse and neglect.
- Intake: #00004558 - CI #2890-000025-21, related to prevention of abuse and neglect.
- Intake: #00008165 - CI #2890-000026-22, related to prevention of abuse and neglect.
- Intake: #00012036 - CI #2890-000031-22, related to prevention of abuse and neglect.
- Intake: #00012117 - CI #2890-000032-22, related to prevention of abuse and neglect.
- Intake: #00014718 - CI #2890-000037-22, related to medication management.
- Intake: #00084246 - CI #2890-000004-23, related to prevention of abuse and neglect.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 20 (1)

The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents, was complied with when an allegation of physical and verbal abuse to a resident, was made.

Rationale and Summary
The home submitted a CI that had alleged physical and verbal abuse by staff towards a resident. It had been submitted 16 days following the date of the allegation.

The licensee's policy, titled, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, indicated any employee who became aware of an alleged, suspected, or witnessed resident incident of abuse or neglect was to report it immediately to the Administrator; designate; reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

The CI and home's investigative notes indicated that a staff member had reported an allegation of resident abuse to a nursing staff member on the date it was to have occurred.

The nursing staff member confirmed they had been informed of the alleged abuse and had not reported the information to anyone as they had not seen the allegation themselves and were unsure if it had occurred.

The staff who had initially reported the allegation, also informed another nursing staff member, 16 days later, who immediately reported the information to the Director of Care (DOC), and the CI was submitted to the Director.

The Administrator confirmed the nurse who the allegation was initially reported to, had not reported it further to the required persons and had not complied with the home's reporting policy for zero tolerance of resident abuse.

Sources: CI report; home's investigative notes; the licensee's policy (RC-02-01-02, reviewed June 2021), and interviews with nursing staff and the Administrator. [214]

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that a resident's device to assist in the management of their diagnosis, was documented when changed, as set out in their plan of care.

Rationale and Summary
A review of a CI indicated that a resident had not been feeling well. The resident had a device that was used to assist in the management of their diagnosis. The device was used on this day and identified a result. Another device was used right after that produced a different result.

a) A review of a resident's health record indicated they had an order to change the first device on set dates in the month. One of the dates that the device was to be changed, documentation indicated the device was not available. No further documentation was observed that the device had been changed on the specified date.

b) A review of the resident's current health record indicated the resident had the same order in place to change the first device on set dates in the month. One of the dates the device was to be changed, documentation indicated the device was not yet due for change. No further documentation was observed that the device had been changed on the date it was due to be changed.

A manager confirmed that no documentation had been in place to identify if the resident's device had been changed on the dates identified, as required in their plan of care. The manager indicated the resident's health record should also have contained an entry for those orders, such as the resident's device changes, that may require administration and documentation outside of their scheduled parameter.

When documentation is missing, this has the potential to compromise the accuracy of the resident's records and may result in the inability to determine if orders were administered as prescribed.

Sources: CI report, review of a resident's health records, and an interview with a manager. [214]

WRITTEN NOTIFICATION: Directives by Minister-Binding on licensees

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to ensure the policy directive issued by the Minister, related to a specified drug administration and management of associated medical conditions, had been carried out.

Rationale and Summary
This Minister's Directive indicated that every licensee was to ensure that all direct care staff received training on the requirements of this Directive.

A review of a CI indicated that a resident had been administered a drug that was specified in this Minister's Directive.

The CI and an interview with a manager indicated the nursing staff involved in the CI, had not received the training requirements of this Directive, prior to the resident's critical incident.

Sources: CI report; the Minister's Directive; staff training records, and an interview with a manager. [214]

WRITTEN NOTIFICATION: Medication management system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure that the written policies and protocols that had been developed for the medication management system to ensure the accurate administration of a resident's drug, were fully developed and implemented.

Rationale and Summary
A licensee's policy, which was confirmed to be a part of the home's medication management program, indicated the nurse would record the administration of the drug from the Medical Directive list on the electronic Medication Administration Record (eMAR). The information should include the drug name, date and time, drug strength, route of administration, and indication that the drug was given as Medical Directive, and the nurse's signature/initials.

A review of a CI indicated that a resident had been administered a drug from their Medical Directives. A review of their eMAR, indicated there had been no documentation that this drug had been administered.

A review of the orders tab in Point Click Care (PCC) identified that no Medical Directives had been listed in the resident's medication profile of this tab.

During a conversation with a manager, they verbalized and demonstrated how to access the Medical Directives as they had not automatically displayed when the user clicked on the orders tab in PCC. A series of steps were required to produce the Medical Directives and following these steps, the user would then be able to document the administration of the Medical Directive onto the eMAR record.

The Medical Directive policy had not contained the above directions on how to access the Medical Directives in the PCC system. The manager confirmed the policy had not been fully developed to provide the user with these directions and had not been implemented when the user had not documented their administration of the drug given to the resident.

When the home's medication management policy, Medical Directives, was not fully developed and implemented, this compromised the accuracy of the resident's drug administration records and had the potential to affect documentation used to identify trends and patterns regarding the use of the specified drug.

Sources: CI report, review of a resident's Medical Directives; eMAR; the licensee's policy (RC-16-01-05, last reviewed March 2023), and an interview with a manager. [214]