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 5, 2024
Inspection Number: 2024-1375-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: Chippawa Creek Care Centre Ltd.
Long Term Care Home and City: Bella Senior Care Residences, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 12-16, August 19-22, 2024.

The following intakes were inspected in this complaint inspection:

- Intake #00114474 was related to nursing and personal support services, and laundry service; and
- Intake #00120635 was related to prevention of abuse and neglect.

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

- Intake #00118388 -Follow-up #1 - High Priority CO #001/2024_1375_0002, O. Reg. 246/22 - s. 74 (2) (c) Nutritional care and hydration programs. CDD June 20, 2024.
- Intake #00119772/CI#2890-000019-24 was related to injury of unknown cause.
- Intake #00120724/CI#2890-000021-24 was related to prevention of abuse and neglect.
- Intake #00120932/CI#2890-000023-24 was related to falls prevention and management; and
- Intake #00123320/CI#2890-000025-24 was related to injury of unknown cause.

The following intakes were completed in this inspection: Intake #00090344/CI#2890-000011-23 and Intake #00115392/CI#2890-000014-24 were related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1375-0002 related to O. Reg. 246/22, s. 74 (2) (c) inspected by Emily Robins (741074)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain Management
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)

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

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,

(c) clear directions to staff and others who provide direct care to the resident; and

1) The licensee of the long-term care home failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident.

Specifically, the home failed to ensure clear direction regarding the transfer needs for a resident.

Rationale and Summary

A resident's most recent safe lift and transfer assessment completed in 2024, identified that the resident required a specified level of assistance with transfers and toileting, and that a specialized device for transfers could be used when fatigued.

Staff acknowledged that the plan of care for a resident could be unclear for direct care staff as the resident's individual plan of care and logos they refer to had missing information. Registered staff updated the transfer logos and plan of care for the resident to clarify their transfer needs prior to the inspection being completed.

Sources: Interviews with registered and direct care staff; observations in August 2024; resident clinical record including assessments, individual care plan (Kardex), transfer logos.

2) The licensee has failed to ensure that the written plan of care for a resident set

out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A resident sustained falls requiring surgical intervention in July 2024 and they required additional assistance from staff. Direct care staff reported the resident had improved since their fall and was now able to transfer with at a specified assistance level for continence care.

The plan of care identified that the resident received continence care in bed and was not to be transferred. Registered staff amended the plan of care on a specified date in August 2024, following an assessment of the resident to ensure the directions were clear.

Sources: Interview with direct care and registered staff; record review of a resident's clinical record.

Date Remedy Implemented: August 21, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (e)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(e) the long-term care home's procedure for initiating complaints to the licensee;

The licensee failed to ensure that the information required to be posted in the home and communicated to residents included the long-term care home's procedures for initiating a complaint to the licensee.

Rationale and Summary

In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home (LTCH) shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, on an identified date in August 2024, the home's information board did not have specific procedures on how to initiate a complaint within the home.

At a later time on the identified date in August 2024, the complaints procedure had been posted on the information board, and it identified how families and residents could have their concerns addressed by initiating the complaints process within the home.

Sources: Observations August 2024; interviews with Resident Support Services Manager (RSSM) and Director of Care; the homes policy title "Complaints and Customer Service" dated November 2023; the homes procedure titled "Complaints Procedure" dated August 2024.

Date Remedy Implemented: August 21, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 9.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
9. Direct contact information, including a telephone number and email address that are monitored regularly for,
i. the Administrator, and

ii. the Director of Nursing and Personal Care.

The licensee failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act included the direct contact information for the Administrator and Director of Nursing and Personal Care (DOC).

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, at an identified date in August 2024, there were no postings in the main lobby, nor on the home's information board for the names, phone numbers, or emails of the Administrator or DOC. Staff acknowledged the missing contact information and updated the information board later that same day.

Sources: Observations August 2024; interview with RSSM and DOC; posting of document titled "Complaint Contacts". [740882]

Date Remedy Implemented: August 21, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

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.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident was identified as having a high risk of falls. The resident had impaired cognition and poor short-term memory.

On an identified date, the resident was initiated on specified checks for safety during periods where risk for falls was increased. The resident was maintained on checks for an identified time period between January and February 2024. The intervention remained in the plan of care to be initiated at any time the resident was at increased risk for falls.

On two occasions, the staff noted that the resident sustained falls, but the specified checks were not in place. Following the second fall, the resident was transferred to the hospital and required surgical intervention.

When the resident was not monitored at the specified frequency, there was actual harm to the resident when they ambulated in an unsafe manner without staff intervention and had two falls.

Sources: Interviews with registered staff and DOC; record review of resident plan of care.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Rationale and Summary
A resident was identified as a high-risk for falls due to identified factors.

Specific instructions were in the resident's plan of care to prevent falls. The resident's plan of care revealed no new interventions after the incident on the specified date. Staff acknowledged that the current care plan was ineffective in managing the resident's falls risk. Following the incident, no reassessment was conducted, nor was the care plan updated.

The failure to reassess the resident and update the plan of care when the initial measures proved ineffective increased the risk of inadequate fall prevention care.

Sources: Interviews with staff; record review of a resident's plan of care.

WRITTEN NOTIFICATION: Duty to protect

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (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.

The licensee failed to ensure that a resident was protected from sexual abuse by another resident on an identified date.

Ontario Regulation 246/22 section 2 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitements d'ordre sexuel")".

Rationale and Summary
On an identified date, direct care staff witnessed a resident commit a sexual act against another resident. The resident was found alone with the other resident at the time of the incident. The resident who committed the act had specific interventions in their plan of care that specified they were not to be left alone with other residents.

The other resident was unaware of what was happening and was not capable of consenting to this or any other sexual activity. Following the incident, the other resident was assessed and monitored for impact. Steps were taken by the home to prevent reoccurrence including additional supervision and identified interventions.

Failure to ensure that a resident was protected from sexual abuse by another resident put the resident at risk of harm.

Sources: Resident progress notes and assessments, and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that where a staff person had reasonable grounds to suspect that abuse of a resident had occurred resulting in risk of harm to the resident, that the suspicion and the information upon which it was based was immediately reported to the Director.

Rationale and Summary
On a specified date, direct care staff witnessed sexual abuse between two residents. The direct care staff reported this incident to the registered staff on duty immediately, however the incident was not forwarded to the Director until two days after. The after-hours line was not called.

Sources: Critical Incident Report, and interviews with staff.

WRITTEN NOTIFICATION: Notification re personal belongings, etc.

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 42 (b)

Notification re personal belongings, etc.
s. 42. Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(b) the resident requires new personal belongings.

The licensee failed to ensure that the substitute decision maker (SDM) for a resident was notified when the resident required new personal belongings.
Specifically, the home did not notify the SDM when a personal belonging was damaged and had to be replaced.

Rationale and Summary
At identified times in 2023, the SDM of a resident was concerned and upset that several personal belongings had damages. The Administrator was made aware and the home compensated for replacement of the the personal belongings.

On a specified date in August 2024, the personal belongings for the resident were observed with the presence of a registered staff member. One identified personal belonging has damages that could require replacement.

Registered staff acknowledged that after the observed damages, they did not notify the SDM regarding the need for new personal belongings and there was no documentation that family had been notified.

The Administrator confirmed the process of notification regarding personal belongings, and acknowledged staff should have notified family upon finding the damaged personal belonging.

Sources: Observations August 2024; interviews with staff; resident progress notes; the homes policy titled "Resident Belongings" dated January 2022.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly.

Rationale and Summary
A resident had an identified altered skin integrity on a date in July 2024, and required weekly skin assessments. Registered staff confirmed a weekly assessment should have been completed for a specified week in August 2024, and that it was not completed.

When the weekly skin assessment was not completed, there was a risk of increased injury, skin breakdown and deterioration to the affected area.

Sources: Interview with registered staff; review of resident clinical record.

WRITTEN NOTIFICATION: Resident records

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
A resident's record indicated that a request for a specified referral was made at their care conference in March 2024. Staff indicated that the referral was completed but not received until June 2024 due to a processing error. Nothing in the resident's written record was found to substantiate that the referral was completed between March when the request was made, and June when the referral was received.

Sources: Resident written and electronic medical records and interview with registered staff.