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: November 4, 2024	
Inspection Number: 2024-1375-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Chippawa Creek Care Centre Ltd.	
Long Term Care Home and City: Bella Senior Care Residences, Niagara Falls	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15-18, 21-22 and 24, 2024

The following intake(s) were inspected:

- Intake: #00128998 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration

Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement
Residents' Rights and Choices
Pain 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 (10) (b)
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A) The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary
A resident's quarterly Minimum Data Set (MDS) assessment included a newly triggered Resident Assessment Protocol (RAP) related to behaviours.

The resident's written plan of care was reviewed and it did not include a focus or interventions related to their behaviours.

A staff member indicated that the resident had a history of demonstrating behaviours and acknowledged their written plan of care should have included the information, based on the MDS assessment.

The resident's plan of care was updated to include the required information.

Sources: A resident's clinical record; staff and resident interviews.

B) The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs changed related to areas of altered skin integrity.

Rationale and Summary
A resident was observed with interventions in place to assist in managing areas of altered skin integrity. The interventions were not included in their plan of care. A registered staff member confirmed the resident's plan of care had not been revised to reflect the implementation of the interventions.

The resident's plan of care was updated to include the required information.

When the resident's skin and wound plan of care was not revised to include current interventions, there was a potential that staff may not be aware of and implement

the interventions in place.

Sources: Resident observations; review of resident clinical records and an interview with registered staff.

Date Remedy Implemented: October 22, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the date a summary of changes had been made to their skin and wound care program, was included in the program evaluation.

Rationale and Summary
Review of the home's skin and wound care program evaluation indicated the home included the continuity of a new wound nurse in their summary of changes made to the program; however, had not included the date this change had been implemented. The program evaluation was revised to include the implementation date.

Sources: Review of skin and wound care program evaluation and staff interviews.

Date Remedy Implemented: October 24, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
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:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the home's visitor policy was posted in the home and communicated to residents.

Rationale and Summary
During a tour of the home, it was observed that the required visitor policy had not been posted in the home. This was confirmed by the Administrator. On the same day, the visitor policy was posted on the home's information board.

Sources: Observations during tour of the home and an interview with the Administrator.

Date Remedy Implemented: October 15, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website

s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that the current report on the continuous quality improvement initiative for the home was published on the website.

Rationale and Summary
The Chippawa Creek at Bella Care Residence website was reviewed, and the report on the continuous quality improvement initiative for the home was posted for 2022. The home's current report for 2024 was not posted, as confirmed by the Administrator.

The current report on the CQI initiative for the home was published on the website.

Sources: Home's website; interview with the Administrator and other staff.

Date Remedy Implemented: October 22, 2024

WRITTEN NOTIFICATION: Plan of care

NC #005 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 a resident was provided with an eating aid, as per their plan of care.

Rationale and Summary
A resident's written plan of care indicated that they required an eating aid at meals. The resident was observed during meal service, and they were not provided with the eating aid.

A staff member acknowledged that the resident still required the eating aid and that it should have been provided as per their plan of care.

Sources: A resident's care plan; resident observations and staff interviews.

WRITTEN NOTIFICATION: General requirements for programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a summary of changes made to their pain program evaluation, including the date that those changes were implemented, was included in the program evaluation.

Rationale and Summary
Review of the home's pain program evaluation, indicated objectives were listed for the program going forward; however, did not contain any changes that were made to the program, including the date that those changes were implemented.

Sources: Review of Palliative care and Pain management program evaluation and staff interviews.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the nursing and personal support services staffing plan evaluation contained a summary of changes made and the date that those changes were implemented.

Rationale and Summary
Review of the staffing plan evaluation indicated the evaluation did not contain a summary of the changes made and the date that those changes were implemented. The evaluation template document did not include an area to document this information.

A staff member indicated that no changes were made to the staffing plan evaluation

and confirmed that this information was not included in the evaluation.

Sources: Review of the nursing and personal support services staffing plan evaluation and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 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 who had an area of altered skin integrity was reassessed weekly.

Rationale and Summary
A resident's clinical record indicated they had an area of altered skin integrity. There were no weekly reassessments conducted for a period of three weeks, as confirmed by registered staff.

When weekly reassessments were not conducted, there was a risk of missing a decline to the altered skin integrity, which had the potential to result in delayed actions taken.

Sources: Resident clinical records; staff interviews.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance.

Rationale and Summary
A Critical Incident System (CIS) indicated the home was declared in an outbreak of a disease of public health significance and the Director was not informed until the following day, as confirmed by a staff member.

Sources: A Critical Incident report; staff interviews.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the continuous quality improvement committee was composed of the required members.

Rationale and Summary
A review of the home's Terms of Reference for their Continuous Quality Improvement (CQI) committee indicated the required members, but listed the Registered Dietitian (RD) and Pharmacist as optional members.

The CQI meeting minutes for 2024 were reviewed, and several of the required members were not documented as attendees or regrets for the two most recent meetings.

The Quality Assurance Lead acknowledged that several individuals were not members of the CQI committee as required, and there was no documentation to support that they were invited or were unable to attend the most recent meetings.

Sources: CQI meeting minutes; TOR; interview with the Quality Assurance Lead.