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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Public Report

Report Issue Date: January 13, 2025
Inspection Number: 2025-1375-0001
Inspection Type: Critical Incident
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 dates: January 6- 10 and January 13, 2025

The following intakes were inspected:

- Intake: #00125101- Critical Incident (CI) related to medication management.
- Intake: #00126084 - CI related to prevention of abuse and neglect.
- Intake: #00126485 - CI related to falls prevention and management.
- Intake: #00128248 - CI related to prevention of abuse and neglect.
- Intake: #00130852 - CI related to prevention of abuse and neglect.
- Intake: #00130930 - CI related to medication management and resident care and support services.
- Intake: #00130997 - CI related to injury of unknown etiology.
- Intake: #00132934 - CI related to prevention of abuse and neglect.
- Intake: #00134302 - CI related to skin and wound care, nutrition and hydration, and pain management.
- Intake: #00134519 - CI related to prevention of abuse and neglect.
- Intake: #00135368 -CI related to prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (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

The licensee has failed to ensure that a resident's plan of care was revised when the home determined that they no longer required a specified intervention. The resident's plan of care was revised on a specified date.

Sources: A resident's care plan, interview with the Director of Care (DOC) and other staff.

Date Remedy Implemented: specified date

WRITTEN NOTIFICATION: Plan of care

NC #002 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 a resident's plan of care was provided as specified when a registered staff administered a specific medication without obtaining a specific vital assessment. The resident's medication orders indicated that they were to receive the specific medication based on a specific order that depended on the vital assessment.

Sources: A resident's clinical record and an interview with an Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 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 a resident's plan of care was revised or reassessed when the resident's care needs changed. A resident acquired a skin alteration on a specified date. The Skin and Wound care lead and the DOC stated that the resident required a specific intervention for the skin alteration. However, this intervention was not entered into the plan of care until 16 days later.

Sources: Interviews with Skin and Wound Care lead and DOC, and review of a resident's clinical record.

WRITTEN NOTIFICATION: Abuse

NC #004 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.

A) The licensee has failed to ensure that a resident was protected from emotional abuse by staff on a specified date.

"Emotional abuse" means "any threatening, insulting, intimidating or humiliating gestures, actions, behaviours, or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

On a specified date, a resident reported that a staff member demonstrated a specified action that had caused them emotional distress.

Sources: A resident's clinical records, home's investigation notes, interviews with the DOC and resident.

B) The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

"Physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

On a specified date, a resident had an altercation with another resident which resulted in a skin alteration and pain.

Sources: CI, resident clinical records, interview with the DOC and other staff.

C) The licensee has failed to protect a resident from physical abuse by another resident.

Section 2 of O. Reg., 246 / 22, defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

On a specified date, there was an incident involving two residents which resulted in one resident sustaining skin alteration injuries.

Sources: Resident clinical records and progress notes, interview with a resident and a Registered Nurse (RN).

D) The licensee has failed to protect a resident from physical abuse by another resident.

Section 2 of O. Reg., 246 / 22, defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

On a specified date, a resident had an altercation with another resident, causing one resident to sustain skin alterations and pain.

Sources: Resident clinical records and progress notes, interview with staff, and CI.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received an intervention to promote healing. On a specified date, the Skin and Wound Care Lead recommended a specified intervention for the skin alteration and a requisition was completed. The resident was provided the specified intervention eight days later. The Skin and Wound Care lead was not informed that the resident was not provided the intervention during those eight days and did not have an opportunity to determine alternate strategies for pressure relief.

Sources: Review of home's specified intervention requisition form, home's investigative notes, and a resident's clinical record, interviews with Skin and Wound Care lead, Resident Support Services Manager, and DOC.

WRITTEN NOTIFICATION: Responsive behaviors

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A) The licensee has failed to ensure that the monitoring of a resident's behavior using the home's Dementia Observation System (DOS) was fully documented. The resident's DOS Data Collection Sheet was missing documentation on multiple specified dates.

Sources: A resident's DOS Data Collection Sheet.

B) The licensee has failed to ensure that the monitoring of a resident's responsive behaviors using the Behavioral Support Ontario- DOS data collection sheet was fully documented. A resident's DOS data collection sheet from specified dates had incomplete documentation on multiple shifts and times.

Sources: A resident's DOS data collection documentation, and an interview with the DOC.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 138 (1) (b)
Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure a resident's controlled substances were stored in a separate locked area within a locked medication cart. On a specified date, a registered staff had left a full narcotic card unattended in a resident's room which resulted in two narcotics missing and unaccounted for.

Sources: CI, investigation notes, Management of Insulin, Narcotics, and Controlled Substances Policy, and interviews with a resident and ADOC.