Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 14, 2013 | 2013_214146_0001 | H-000386-12, H-000020-12 | Complaint |

**Licensee/Titulaire de permis**

BELLA SENIOR CARE RESIDENCES INC.
1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5

**Long-Term Care Home/Foyer de soins de longue durée**

BELLA SENIOR CARE RESIDENCES INC.
8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

BARBARA NAYKALYK-HUNT (146)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 9, 10, 2013**

**This inspection was conducted for 2 complaints H-000386-12 and H-000020-12.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered staff, Personal Support Workers (PSW'S) and residents.**

**During the course of the inspection, the inspector(s) toured the home, reviewed resident health records, policy and procedures related to Substitute Decision Maker (SDM) notification and specific complaint records.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**

**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | WAO – Ordres : travaux et activités |

| | |
|---|---|
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the resident, SDM, if any and any other persons designated by the resident/SDM had been given the opportunity to participate fully in the development and implementation of the plan of care.
i. According to the health record, in February 2012, resident 001's SDM requested to know if resident 001's medications were changed after the physician came in 2 days previous. A review with the nurse revealed that there was a medication change made about which the SDM had not been notified.
ii. In June 2012, resident 002's family member informed staff that the SDM/POA had not been called when resident 002 refused care the day before, despite previous POA documented request in May 2012 to be notified of any care refusals. The POA wished to be able to convince the resident to accept care when such occasions arose. Staff confirmed resident 002 had refused care and POA had not been notified.
iii. According to progress notes of resident 001, the POA requested on 3 occasions: in November 2011, December 2011 and February 2012 that the POA be called with any information re: resident 001's medication changes, medication refusals and/or health changes. According to progress notes, resident 001 had multiple episodes of chest and back pain and there is no evidence the POA was notified on these specific dates in July, August and October 2011 . According to the DOC, if POA notification had been done on any occasion, it would have been documented in progress notes.
iv. Random review of progress notes revealed that resident 001 frequently refused medications and the POA was not notified of the refusal in June 2011, August 2011 and November 2011. [s. 6. (5)]

2. 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.
i. The plan of care of resident 002 was revised in June 2012 and stated that denture paste was to be applied to the resident's dentures before inserting them into the resident's mouth. This was to prevent the resident removing them since one set had been lost and recently been replaced. Later on 2 dates in June 2012, the resident's family member informed the staff the paste had not been applied on both dates. This information was confirmed by the health record and the Administrator.
ii. The plan of care for resident 002 was revised in August 2011 to state "Staff to apply hearing aids in am and remove in pm (sign on MARS)". This was to prevent the loss of the resident's hearing aids. According to a review of the MARS, staff did not sign the MARS to indicate either application of or removal of the hearing aids on multiple occasions: November 2011- 17 times; December 2011 - 7 times; January 2012 - 20 times; February 2012 - 13 times; March 2012 - 10 times. According to a

family member's report, hearing aids were not applied or not applied correctly on 3 dates in May and June 2012. In June 2012 the hearing aids were missing and not found. This information was confirmed by the Administrator and DOC. [s. 6. (7)]

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system is
(b) complied with.
i.Bella Senior Care Resident Services Manual Section 8.3 "Documentation: processing physician's orders" states that when the physician orders any new medications or makes changes to or discontinues medications, part of the processing procedure is to notify the resident's POA and document in progress notes this has been completed.
ii. According to the health record, medication changes were ordered for resident 001 3 times in August 2011, once in November 2011 and 2 times in February 2012. There was no documentation that the POA was notified. This was confirmed by the POA, the records and the DOC.
iii. A random check of residents records revealed that:
resident 003 had 2 occasions where medications were changed and the POA was not notified in September 2012 and November 2012;
resident 004 had 2 occasions of medication changes where the POA was not notified in October 2012;
resident 005 had 3 occasions of med changes where the POA was not notified in October 2012 and January 2013. [s. 8. (1) (b)]

**Issued on this 21st day of January, 2013**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**