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
Sep 6, 2013	2013_202165_0013	H-000504-13	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

TAMMY SZYMANOWSKI (165)

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): August 14, 15, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager, Dietitian, Registered Practical Nurse (RPN), personal support workers, dietary staff, Assistant Director of Care

During the course of the inspection, the inspector(s) observed meal service and reviewed clinical health record

The following Inspection Protocols were used during this inspection:

1. The licensee did not ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.
A) The eating plan of care had a focus statement that indicated that the resident required extensive assistance related to impaired vision and cognitive impairment. The interventions identified that staff were to provide constant encouragement and remain with the resident during meals. Staff interviewed stated that the resident ate independently without assistance and staff did not sit with the resident during a dinner meal in June 2013.
B) The plan of care for eating and moderate nutritional risk indicated the resident was to receive a textured diet. Staff interviewed confirmed that during a dinner meal in June 2013, resident #001 was served the incorrect texture for dessert; the resident reported to staff and staff noted that the resident ate some of the dessert. The resident identified to the staff that there was something stuck in their throat and subsequently the resident choked.
C) The plan of care kardex for resident #002 indicated the resident was to receive a regular texture and staff were to remove the crust from bread. During the lunch meal August 15, 2013, the resident received half a cheese sandwich with the crust left on. The resident ate the sandwich leaving the crust on their plate. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that residents were not neglected by the licensee or staff.
A) Staff confirmed that resident #001 was served the incorrect textured dessert and ate some of the dessert during a dinner meal in June 2013. The resident identified to the RPN that there was something stuck in their throat. The RPN stayed with the resident at their table and encouraged the resident to swallow. Progress notes indicated that the RPN observed that the resident had physical signs of difficulties however; the RPN confirmed that no interventions were initiated at this time and there was no assessment of the residents airway completed. The RPN sat with the resident at the table and provided reassurance. The resident proceeded to clear the blockage themself however, was unsuccessful. The resident started to become more distressed and documentation confirmed that the RPN then called the Registered Nurse for further assessment and direction. The home's emergency care policy last revised June 2013, indicated that establishing an open airway was the first step in emergency care and the nurse must provide an adequate airway for the resident. The policy stated that when there was a partial obstruction the nursing staff should allow the resident time to dislodge the obstruction on their own however; with a complete airway obstruction the nurse must perform the Heimlich maneuver immediately. Progress notes indicated that the RPN did not perform an assessment of the resident's airway to determine if it was a partial or complete blockage, the RPN confirmed that they did not perform actions to dislodge the obstruction immediately and actions were not attempted to clear the airway until the RN arrived. The DOC stated that first aide training including CPR was completed yearly however; records indicated that the registered staff had not completed training in 2012, and was not provided the training until after the incident occurred. The DOC was not able to verify that staff were provided education and were aware of the procedures in the emergency care policy. The licensee failed to provide the resident with treatment, care or assistance required for health, safety or well-being, including inaction that jeopardized the health, safety or well-being of the resident. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Issued on this 17th day of September, 2013

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

Tammy Szymanowski