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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 12, 2016 | 2016_247508_0008 | 012872-16 | 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

ROSEANNE WESTERN (508), KERRY ABBOTT (631)

## 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): May 4, 5, 11, 18, 19, 24, June 7, 8, 10, 14, 2016.**

**Please note: complaint inspections #015089-16, #015832-16, #016544-16, related to improper care of a resident, and Critical Incident report #017966-16, related to neglect of a resident were conducted concurrently during this complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Nurse Manager, the Life Enrichment Co-ordinator, the Resident Assessment Instrument (RAI) Co-ordinator, the Recreation Manager, recreation aides, registered staff, Personal Care Providers (PCP), residents and family.**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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. 6. Plan of care**

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

**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,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**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).**

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #004 was admitted to the home on an identified date in 2014, with a treatment order. In January, 2015, the resident developed an infection and the physician increased the treatment order.

A review of the resident's current plan of care indicated that the plan directed staff to administer the treatment based on the original physician order. The Medication Administration Record (eMAR) directed staff to administer the treatment at the most recent order. The resident was observed receiving the treatment during this inspection as per the most current order; however, the resident's plan of care still indicated that the resident was to receive this treatment as ordered upon admission.

It was confirmed by staff #106 during an interview on May 19, 2016, that the plan of care for resident #004 did not set out clear directions to staff and others who provided direct

care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #001 was admitted to the home on an identified date in 2016, and a recreation and leisure assessment had been completed with the assistance of a family member.

A review of this assessment indicated that the resident enjoyed listening to music, religious activities, parties/seasonal programs, gardening, watching television/movies, dancing, painting, reading, bingo, concerts and plays, needlework and baking.

A review of the resident's plan of care, which this assessment was based on, did not include all of the resident's assessed past and present interests. The plan only identified some of the resident's interests.

It was confirmed through clinical documentation and during an interview with the Administrator on May 24, 2016, that the care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

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

Resident #001 had a chronic condition and required a continuous treatment intervention. In May, 2016, it was identified by a visitor that resident #001 had a change in their condition and it was identified that the treatment ordered for the resident's condition was not being administered as ordered.

Staff #106 who was responsible for ensuring that the resident received their treatment as ordered thought they had provided the treatment as ordered; however, there was no documentation to confirm that this had been done.

During an interview with the Director of Care (DOC) on May 19, 2016, the DOC stated that it had been verified that the resident had not received their treatment as ordered on this identified date. This was also confirmed by the Administrator on May 24, 2016.

It was confirmed by the DOC and the Administrator during an interview on May 24, 2016, that the care set out in the plan of care was not provided to the resident as specified in

the plan. [s. 6. (7)]

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

Resident #001 required a specific device to receive their necessary treatment to maintain the resident's independence.

In June, 2016, the resident's visitor had identified that the resident's specific device that the they were supposed to have was not the correct size and reported this to the Registered Nurse (RN). The RN went to the resident's room and verified that the resident's specific device that they required had not been provided to the resident as specified in the plan.

It was confirmed by staff #110 during an interview on June 8, 2016, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #004 was admitted to the home on an identified date in 2014, and had a diagnosis of a chronic condition. Admission orders included that the resident was to receive treatment at a specified amount.

In January, 2015, the resident developed an infection and the treatment that was originally ordered was increased.

Documentation in the resident's clinical record indicated that after the treatment order had changed, the resident had been administered their treatment at the original amount, not the most recent order. The resident's most recent plan of care, that staff referred to for direction in providing care to residents, also indicated that the resident was to receive their treatment as per the original order.

It was confirmed by staff #106 during an interview on May 19, 2016, that care had not been provided to resident #004 as specified in the resident's plan of care. [s. 6. (7)]

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

Resident #001 required extensive assistance of one staff for transfers. A bed alarm had been applied to the resident's bed due to a risk of falls.

On an identified date in 2016, the resident's visitor had identified that the resident's bed alarm was not activated. They notified the Registered Nurse (RN) and the RN came into assess the resident's bed alarm. The RN identified that the resident's bed alarm connection was loose and he immediately reconnected the wiring and retested the bed alarm to ensure it was reactivated.

A review of the resident's plan of care under the focus of falls prevention, indicated that the staff were to ensure that the batteries were operational and the alarm was activated and to monitor hourly for safety.

It was confirmed through documentation and by staff #109, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #001 was prescribed a continuous treatment intervention due to health conditions; however, it had been identified that the resident was not compliant with this intervention which caused the resident's condition to worsen.

Interventions implemented in the resident's plan of care included increased monitoring of the resident to ensure the resident was receiving their treatment. The plan directed staff to check on the resident regularly to ensure the resident was receiving their treatment.

According to a Critical Incident (CI) report, on an identified date in June, 2016, it was identified that staff working on this shift who were caring for resident #001 failed to check on the resident as directed in the plan.

It was confirmed by the Director of Care and the Administrator on June 15, 2016, that staff did not provide care to resident #001 as specified in the plan. [s. 6. (7)]

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

Resident #001 was prescribed to have a specific treatment intervention. On an identified date in May, 2016, staff #108 observed resident #001 outside of the resident's room after leaving the dining room from dinner service. Staff #108 assisted resident #001 to a chair in the resident's room and did not check to ensure that the resident's treatment was being administered as ordered.

Staff #108 confirmed during an interview on May 26, 2016, that when she assisted the resident the resident's treatment was not being administered as ordered. This information was also confirmed by a family member who visited the resident later that evening.

It was confirmed by staff #108 during an interview that the care set out in the plan of care had not been provided to the resident as specified in the plan. [s. 6. (7)]

9. The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and given convenient and immediate access to it.

A review of resident #001's plan of care and medication administration record (eMAR) indicated that there was an order for the resident to receive a specified treatment intervention.

A review of the resident's New Admission Order Form indicated that the resident's treatment equipment was to be checked every shift and to change treatment equipment as needed (PRN). A review of the resident's corresponding Medication Administration Record (eMAR) and Treatment Administration Record (eTAR) indicated that this order was not transcribed. Therefore, there was no direction to staff to ensure the resident's treatment equipment was being monitored and changed as required.

An interview with staff #101 and #106 as well as with the Administrator and DOC confirmed that there were no orders on the eMar or eTAR with these specific directions. (#631) [s. 6. (8)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and given convenient and immediate access to it and to ensure that the plan of care for each residents sets out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(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. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that for each resident who demonstrated responsive behaviours, including resident #001, strategies were developed and implemented to respond to these behaviours, where possible.

The resident was observed by Inspector #508 several times each day of this inspection with their treatment being administered as ordered; however, after initial observations, the resident was observed with their treatment intervention off. This was immediately reported to staff #006 by the Inspector and the resident's treatment was re-applied by staff.

A review of the resident's clinical record and staff interviews indicated that resident #001 would remove the required treatment after it was applied by staff and would also play with the treatment equipment. Due to this, resident #001 had been witnessed by staff and visitors to be without their prescribed treatment.

A review of the resident's plan of care indicated that there had been no strategies developed or implemented to manage the resident's responsive behaviours.

It was confirmed by staff #106 and the Director of Care during an interview on May 24, 2016, that when resident #001 demonstrated responsive behaviours strategies had not been developed and implemented to respond to these behaviours. [s. 53. (4) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident who demonstrates responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training**

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

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in accordance with O. Reg.79/10, s. 219(1), in relation to the following: behavioural management.[76(7)]

During this inspection it was identified that retraining in the area of behaviour management had not been provided to staff who continued to have contact with residents. The home could not provide documentation to confirm that retraining in this area had been completed in 2015 or 2016.

An interview with the Assistant Director of Care (ADOC) and the Administrator on June 10, 2016, confirmed that retraining in the area of behaviour management had not been provided to staff who continued to have contact with residents. [s. 76. (7) 3.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive as a condition of continuing to have contact with residents, annual retraining in relation to responsive behaviours, to be implemented voluntarily.***

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**WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

During this inspection, it had been brought to the attention of the Inspector that staff #104 was witnessed being disrespectful towards resident #001 and a family member on an identified date in May, 2016.

During an interview with staff #104 on June 7, 2016, the staff confirmed this allegation and indicated that she has since regretted her actions.

A review of the Employee Conduct policy, under the Appropriate Conduct and Behaviour section, indicated that appropriate conduct and behaviour included but was not limited to:

Courtesy to and respect for residents, families, visitors and coworkers or any other person who had dealings with the home.

The Administrator verified the allegation after an internal investigation had been completed. It was also confirmed by the Administrator during an interview on June 7, 2016, that the staff did not comply with the home's Employee Conduct policy. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints**

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

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any written complaints that had been received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

On May 4, 2016, an interview was conducted by Inspector #631 with the Director of Care (DOC) and the Administrator. The DOC advised the inspector that between specified dates in March and April, 2016, the home had received several emails regarding concerns related to care of resident #001. The DOC confirmed that the home failed to forward any of the written complaints from the complainant to the Director. [s. 22. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any written complaints that are received concerning the care of a resident or the operation of the home are immediately forwarded to the Director, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

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

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

An interview with the Substitute Decision Maker (SDM) indicated that on April 27, 2016, the SDM had requested that the resident #001 receive foot care as the resident's toenails were very long. At that time, the SDM was notified by the staff that a signed consent form was required; however, according to the SDM, a form was never made available to sign.

Interviews conducted with staff #100, #101 and #106, indicated that no foot care was provided to the resident from their date of admission on an identified date in March, 2016, to the date of this inspection. A review of the resident #001's clinical record indicated that no foot care was provided to the resident.

On May 5, 2016, while reviewing resident #001's chart, inspector #631 noted an unsigned copy of a foot care consent form clipped to the front of the resident's chart. On May 5, 2016, inspector #631 observed resident #001 seated in their room. On May 5, 2016, at 1100 hours, inspector #631 observed resident #001's toe nails to appear thick and in need of trimming. An interview with personal support worker (PSW) staff #100 and #102 on May 5, 2016, indicated that the PSWs did not provide foot care for resident #001 and that the resident received foot care from "someone that comes in".

An interview with registered staff #101 on May 5, 2016, indicated that the PSW staff provided foot care for resident #001. An interview with registered staff #106 on May 5, 2016, confirmed that resident #001 had not received foot care since admission and that the Registered Nurse had provided foot care for resident #001 for the first time on May 5, 2016. [s. 35. (1)]

**Issued on this 13th day of July, 2016**

| |
|---|
| **Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs** |

**Original report signed by the inspector.**

Ontario

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

**Order(s) of the Inspector**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

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

**Ordre(s) de l'inspecteur**
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ROSEANNE WESTERN (508), KERRY ABBOTT (631) |
| **Inspection No. / No de l'inspection :** | 2016_247508_0008 |
| **Log No. / Registre no:** | 012872-16 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jul 12, 2016 |
| **Licensee / Titulaire de permis :** | BELLA SENIOR CARE RESIDENCES INC.<br>1000 FINCH AVENUE WEST, SUITE 901, TORONTO, ON, M3J-2V5 |
| **LTC Home / Foyer de SLD :** | BELLA SENIOR CARE RESIDENCES INC.<br>8720 Willoughby Drive, NIAGARA FALLS, ON, L2G-7X3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Dale Cowan |

To BELLA SENIOR CARE RESIDENCES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007, 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).

**Order / Ordre :**

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

Previously issued as a VPC on March 10, 2016.

1. The licensee shall review the plan of care for resident #001 and update the plan to include the following:

a) All treatment orders are to be administered as per Physician's orders.
b) Identify responsive behaviours and develop interventions to manage the resident's care needs related to treatment administration and falls prevention.

2. Review all of the plans of care for resident's receiving treatments to ensure that all plans are current and accurate.

3. Ensure that all staff that are managing residents receiving treatments have access to the plans.

4. Ensure that all actions taken in relation to the administration of medications and treatments are documented.

The Order is made based upon the application of the factors of severity (2), scope (2) and compliance history (4), in keeping with s.299 (1) of the Regulation, in respect to the risk or potential for harm of the resident, the pattern of six examples and the licensee's history of on-going non compliance previously issued as a VPC in March, 2016.

**Grounds / Motifs :**

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

Resident #001 had a chronic condition and required a continuous treatment intervention. In May, 2016, it was identified by a visitor that resident #001 had a change in their condition and it was identified that the treatment ordered for the resident's condition was not being administered as ordered.

Staff #106 who was responsible for ensuring that the resident received their treatment as ordered thought they had provided the treatment as ordered; however, there was no documentation to confirm that this had been done.

During an interview with the Director of Care (DOC) on May 19, 2016, the DOC stated that it had been verified that the resident had not received their treatment as ordered on this identified date. This was also confirmed by the Administrator on May 24, 2016.

It was confirmed by the DOC and the Administrator during an interview on May 24, 2016, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #001 required a specific device to receive their necessary treatment to maintain the resident's independence.

In June, 2016, the resident's visitor had identified that the resident's specific device that the they were supposed to have was not the correct size and reported this to the Registered Nurse (RN). The RN went to the resident's room and verified that the resident's specific device that they required had not been provided to the resident as specified in the plan.

It was confirmed by staff #110 during an interview on June 8, 2016, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #004 was admitted to the home on an identified date in 2014, and had a diagnosis of a chronic condition. Admission orders included that the resident was to receive treatment at a specified amount.

In January, 2015, the resident developed an infection and the treatment that was originally ordered was increased.

Documentation in the resident's clinical record indicated that after the treatment order had changed, the resident had been administered their treatment at the original amount, not the most recent order. The resident's most recent plan of care, that staff referred to for direction in providing care to residents, also indicated that the resident was to receive their treatment as per the original order.

It was confirmed by staff #106 during an interview on May 19, 2016, that care had not been provided to resident #004 as specified in the resident's plan of care. [s. 6. (7)]

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

Resident #001 required extensive assistance of one staff for transfers. A bed alarm had been applied to the resident's bed due to a risk of falls.

On an identified date in 2016, the resident's visitor had identified that the resident's bed alarm was not activated. They notified the Registered Nurse (RN) and the RN came into assess the resident's bed alarm. The RN identified that the resident's bed alarm connection was loose and he immediately reconnected the wiring and retested the bed alarm to ensure it was reactivated.

A review of the resident's plan of care under the focus of falls prevention, indicated that the staff were to ensure that the batteries were operational and the alarm was activated and to monitor hourly for safety.

It was confirmed through documentation and by staff #109, that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

Resident #001 was prescribed a continuous treatment intervention due to health conditions; however, it had been identified that the resident was not compliant with this intervention which caused the resident's condition to worsen.

Interventions implemented in the resident's plan of care included increased monitoring of the resident to ensure the resident was receiving their treatment. The plan directed staff to check on the resident regularly to ensure the resident was receiving their treatment.

According to a Critical Incident (CI) report, on an identified date in June, 2016, it was identified that staff working on this shift who were caring for resident #001 failed to check on the resident as directed in the plan.

It was confirmed by the Director of Care and the Administrator on June 15, 2016, that staff did not provide care to resident #001 as specified in the plan. [s. 6. (7)]

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

Resident #001 was prescribed to have a specific treatment intervention. On an identified date in May, 2016, staff #108 observed resident #001 outside of the resident's room after leaving the dining room from dinner service. Staff #108 assisted resident #001 to a chair in the resident's room and did not check to ensure that the resident's treatment was being administered as ordered.

Staff #108 confirmed during an interview on May 26, 2016, that when she assisted the resident the resident's treatment was not being administered as ordered. This information was also confirmed by a family member who visited the resident later that evening.

It was confirmed by staff #108 during an interview that the care set out in the plan of care had not been provided to the resident as specified in the plan. [s. 6. (7)]

(508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2016

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 12th day of July, 2016**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Roseanne Western

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office