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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 6, 2016	2016_323130_0016	009439-16, 012482-16, 022967-16, 023930-16, 024930-16, 025588-16, 026797-16	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

GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583)

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 24, 25, 26, 29, 30, 31, September 1, 6, 7, 8, 13, 14, 15, 19, 2016.

Please note, the following complaint inspections were conducted concurrently with this inspection: #024528-16 and #025848-16.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, registered staff, physiotherapy staff, recreation staff, personal care providers (PCPs), nursing unit clerks, Social Services Worker, Environmental Services Manager, housekeeping staff, dietary staff, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Food Quality
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours
Safe and Secure Home

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. (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. (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 failed to ensure that the written plan of care for each resident that set out the planned care for the resident provided clear directions to staff and others who provided direct care to the resident.

A) The written plan of care for resident #100, revised in August 2016, directed staff to monitor hourly to ensure the resident was compliant with an ordered treatment. The written plan also directed staff to check on the resident every 30 minutes and more frequently if required to ensure the appropriate management of the treatment.The flow sheet that was developed for staff to document the treatment and monitoring activities, directed staff to initial the flow sheet every 30 minutes, which provided conflicting direction from the written plan of care.
The DOC confirmed resident #100's plan of care did not provide clear direction to staff.

This non compliance was identified as a result of the following complaint inspection. #023930-16. (Inspector #130). [s. 6. (1) (c)]

2. 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.

A) The plan of care for resident #100 directed staff to take the resident to the toilet when they awaken, after meals, mid- morning, afternoon, before bed and when requested.

On a specified date in September 2016, staff #028 confirmed that they toileted the resident at 0645 hours. PCP #028, #067 and #084, confirmed the resident was not

toileted after breakfast as per the plan of care.

This non-compliance was issued as a result of the following complaint inspection #02390 -16. (Inspector #130).

B) The plan of care for resident #112 directed staff to ensure that their safety device was in place and secure when the resident was up in their wheelchair.

On an identified date in May 2016, PCP #041 portered resident #112 from the shower room, down the hallway. The resident unexpectedly put their feet on the ground while the wheelchair was moving, which caused the resident to fall forward onto the floor. The resident did not suffer any injury as a result of the fall. Staff confirmed the safety device was not fastened at the time of the fall, as specified in the plan of care. This non compliance was issued as a result of the following complaint inspection #02558-16. (Inspector #130).

C) A review of resident #110's clinical record identified that the resident was a high risk for falls and had sustained a number of falls over a two month period in 2016. A review of the resident's current written plan of care indicated under the falls prevention program interventions that staff were to put a specific intervention in place when the resident was up and if the resident refused to re-approach later.

During an interview and observation of the resident on two specific dated in 2016, it was indicated that the resident did not have intervention in place. An interview with PCPs #065, #071 and #217, confirmed that they were not aware of the intervention had had not initiated it on the two specified dates in 2016. An interview with the DOC confirmed that care had not been provided to the resident as specified in their plan.

This non compliance was identified as a result of the following complaint inspection. #022967-16. (Inspector #214). [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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 demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

A) A review of resident #110's clinical record indicated that the resident demonstrated responsive behaviours. A review of progress notes indicated that on three identified dates in July 2016, the resident made attempts to leave the home. A progress note on a specified date in July 2016, indicated that the resident was found outside the home. An interview with the Social Worker confirmed that the resident was not safe to be outside by themselves.

A review of the resident's written plan of care indicated under wandering that staff was to allow the resident to wander on the unit and to initiate behaviour mapping review and monitor for patterns or trends as needed. No strategies or interventions had been included to respond to the resident's behaviour when they wandered off their unit or outside of the home. An interview with the DOC confirmed that strategies had not been developed and implemented to respond to the resident's responsive behaviour off the unit and outside of the home.

This non compliance was identified as a result of the following complaint inspection. #022967-16. (Inspector #214). [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 demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #3: 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.

A review of the home's policy titled, "Falls Prevention Program" (Subsection 3.6 and dated with a reviewed date of June 2015), indicated the following:

i) Registered staff will initiate a plan of care to address residents identified as a high risk and implement high risk strategies such as a visual management system, high fall-risk magnet/signage by bed.

A review of resident #110's clinical record identified the resident was assessed to be a high risk for falls since admission in 2016 and quarterly thereafter. A review of the resident's progress notes confirmed that falling stars had not been placed on the resident's equipment, outside the room door and at the head of the bed until a later date in 2016.

An interview with the DOC confirmed that the home had not complied with their Falls Management policy related to the implementation of the falling star program.

This non compliance was identified as a result of the following complaint inspection. #022967-16. (Inspector #214). [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The plan of care for resident #100, directed PSWs to initial each time slot on a specifically developed flow sheet, to monitor an identified treatment, every 30 minutes when the items identified on the sheet had been checked. A review of this flow sheet over a one month period in 2016, showed that on multiple shifts, staff had not consistently initialed the flow sheet. Staff confirmed that the resident consistently had the treatment applied, but they had not initialed the flow sheet as required.

This non compliance was issued as a result of the following complaint inspection # 023930-16. (Inspector #130).

B) A review of resident #110's clinical record identified that the resident was a high risk for falling and had sustained a number of falls over a two month period in 2016. A review of the resident's current written plan of care indicated under the falls prevention program interventions that the resident was on a toileting schedule to prevent falls and that staff were to assist the resident to the toilet every two hours while awake from 0800 hours to 2000 hours and when needed. A review of the Point Of Care (POC) task for toileting over a specified time period in 2016, indicated that documentation for toileting the resident every two hours while awake and when needed, had not been completed every two hours. An interview with front line staff #065 and #217 confirmed that they were aware that the resident was to be assisted to the toilet every two hours while awake; however, not all actions taken with respect to the resident's toileting plan had been documented. An interview with the DOC confirmed that not all actions taken had been documented.

This non compliance was identified as a result of the following complaint inspection.

#022967-16. (Inspector #214).

C) A review of resident #110's clinical record indicated that the resident demonstrated responsive behaviours. A review of progress notes indicated that on three identified dates in 2016, the resident made attempts to leave the home. A progress note on a specified date in 2016, indicated that the resident was found outside the home.

A review of the resident's written care plan directed staff to initiate the behaviour mapping review and monitor for patterns and trends as needed. An interview with the RAI Coordinator confirmed that the Dementia Observational System (DOS) Tool was to be used for the behaviour mapping. The RAI Coordinator indicated that the DOS was to be implemented with each episode of responsive behaviour and would be done for a period of three to four days in which a progress note would be completed summarizing the information collected.

A review of the resident's clinical record indicated that a form titled, "15 Minute Check Flowsheet", which contained codes to document specific responsive behaviours, had been implemented for a specified time period in 2016. The form instructed staff to use the corresponding numbers to record in 15 minute intervals. A review of this documentation indicated that the form was blank and not completed over a number of identified dates, at specified times in 2016, A review of the resident's progress notes over a six day time period in 2016, indicated that no documentation had been included summarizing the information collected on the "15 Minute Check Flowsheet".

An interview with the DOC confirmed that the staff did check on the resident; however, not all actions taken with regards to the assessment of the resident's responsive behaviours, had been documented.

This non compliance was identified as a result of the following complaint inspection. #022967-16. (Inspector #214). [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) Resident #121 sustained falls with minor injuries on six identified dates in 2016; according to the clinical record, there were no post fall assessments completed for these falls, using a clinically appropriate assessment instrument that was specifically designed for falls. The RAI Coordinator confirmed there should have been post fall assessments completed after these falls.

This non compliance was issued as a result of the following complaint inspection #025848-16. (Inspector #130). [s. 49. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the nutrition manager was onsite at the home working in the capacity of the nutrition manager for the minimum number of hours per week as calculated under subsection (4).

A) In an interview with the Director of Care on September 14, 2016 and upon review of the "Bella Senior Care Residences Inc. Census August 2016" it was identified the home's bed occupancy was 161. It was confirmed for the month of August 2016 that the occupancy of the home was 97 percent or greater.

M = 161 x 8/25
M = 51.5 hours per week

A review of the payroll records identified that the nutrition manager worked on site in the capacity of the nutrition manager for 74 hours from August 1 to August 14, 2016 and for 64 hours from August 15 to August 28, 2016. Over a two week pay period the minimum required hours were 103 hours. In documentation provided by the Administrator on August 30, 2016, it was confirmed that the home did not have a nutrition manager onsite working for the minimum number of required hours over a four week period in August 2016. (Inspector #583). [s. 75. (3)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 did not 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 the area of Behaviour management in relation to the following: [76(7)3].

An interview with the DOC indicated that in June 2016, the home was no longer using an online learning management system that was previously used to provide education and training to staff. The DOC confirmed that the home was unable to provide documentation that the 129 staff who provided direct care to residents received retraining in the area of behaviour management in 2015 as the home was unable to retrieve the training records from the previously used online learning system and were unable to locate these training records in the home.

PLEASE NOTE: The above noted non-compliance was identified while conducting a Complaint Inspection #022967-16 (Inspector #214). [s. 76. (7) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that ensure that the Director was 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 (4): 2. An unexpected or sudden death, including a death resulting from an accident or suicide.

A) On an identified date in 2016, resident #111, was transferred to hospital as their condition continued to deteriorate. The resident passed away in hospital. The DOC confirmed the resident's death was unexpected and that a CI should have been submitted. This non-compliance was issued as a result of the following complaint: # 025588-16. (Inspector #130). [s. 107. (1) 2.]

Issued on this 31st day of October, 2016

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

Original report signed by the inspector.