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
Oct 27, 2016	2016_250511_0012	020182-16	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

ROBIN MACKIE (511)

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): September 1, 2, 6, 16, 27, 28, 29, 2016.

This Inspection is for Complaint #020182-16 in relation to a resident discharge

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Support Services Manager, RAI Coordinator/MDS, Community Care Access Centre (CCAC) Case Manager (CM), Recreation aides and Resident Substitute Decision Maker (SDM)

During the course of the inspection, the inspector(s) observed resident care, reviewed specific resident clinical records and the home's applicable policy and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. (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 has 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 admitted to Bella Senior Care Residences Inc. ("the home") in 2016, with cognitive impairment.

On their admission, the resident demonstrated responsive behaviours when approached for care. A referral had been faxed to Behavioural Supports Ontario (BSO) for an urgent assessment and the Seniors Mental Health Outreach (SMHO) had been contacted. SMHO had suggested the home complete a test to rule out a condition that may have been a contributing factor to the resident's behaviour. A review of the clinical record and interview with the DOC confirmed the test was not completed.

The DOC confirmed the licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that before a resident was discharged under subsection 145(1), there was b) collaboration with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident, c) that the resident and the resident's substitute decision maker, were kept informed and given opportunity to participate in the discharge planning and that her wishes were taken into consideration.

Resident #001 was admitted to the home in 2016 with cognitive impairment. A review of the admission note, located in the clinical record, indicated the resident required extensive assistance with their activities of daily living. They had a history that included some responsive behaviours, prior to admission, that had been easily redirected and documented as diminished with medication changes. The home's social worker indicated assistance would be required with the resident's transition into the Long Term Care home. Recreation activities the resident had enjoyed were identified in the admission note.

A review of the Community Care Access Centre (CCAC) Case notes, indicated that the

home had called the CCAC shortly after admission. These case notes indicated the Director of Care (DOC) had reviewed their concern with the CCAC on the placement of the resident due to a responsive behaviour. The CCAC documentation further confirmed that encouragement had been provided and that the home would provide staffing to keep the patient safe until another room/placement could be obtained on another unit within the home.

On a later date in 2016, the resident demonstrated behaviours and a referral was faxed to Behavioural Supports Ontario (BSO) for an urgent assessment and the Seniors Mental Health Outreach (SMHO) was contacted.

On a later date in 2016, the resident's physician provided medication changes. The documentation indicated the resident continued with responsive behaviours and the DOC contacted the CCAC and the DOC was made aware that the resident was on a Long Term Care crisis list for a transfer to another Long Term Care home. The resident was also on a list for an internal move to another unit within Bella Senior Care Residences Inc.

On several dates in 2016, documentation described that the resident's responsive behaviors would escalate and respond to some identified interventions. The BSO assessed the resident and identified the resident had pain and had no pain medications ordered. The BSO suggested pain assessments be completed every shift and the physician was to be notified for an order for pain medication. An order was received to provide medication when needed for pain. The resident continued to demonstrate responsive behaviours. A BSO note indicated the Dementia Observational System (DOS) charting, for a seven day period of time, had reflected some improvement in the resident's behaviours. The resident's Substitute Decision Maker (SDM) contacted the CCAC and stated they felt their family member had also improved in relation to recent medication changes. A new order for a pain medication was ordered and the BSO documentation, confirmed the medication was to address the pain as a contributing trigger for resident #001's responsive behaviours. BSO had recommended that DOS charting remain ongoing to monitor the effectiveness of this intervention.

The CCAC's plan was reviewed with the home's DOC and included:
1. A specific test to rule out a condition as a contributing factor for the behavior
2. Contact Geriatric outreach and BSO for intervention assistance
3. Suggest Senior Care to review the information

A progress note, completed by a Registered Practical Nurse, indicated they provided an intervention and indicated that providing this intervention may have been effective to address the resident's responsive behavior. This intervention was to be further implemented and monitored for effectiveness in reducing the resident's behaviour. There was no documentation to confirm this intervention was further implemented, monitored or evaluated for effectiveness. There was no evidence that the test was carried out.

The resident continued to exhibit some responsive behaviours as identified in the behavioural tracking notes. A follow-up call to the SMHO was completed by the Associate Director Of Care (ADOC). It was documented that a discussion occurred between the SMHO and the ADOC regarding the resident's behaviours and a request for a follow-up on the referral for SMHO. The SMHO stated they would be able to come to the home, with their physician, on a later date. The progress note further identified the option for the resident to be sent, by the home's physician, to the hospital for further assessment. The ADOC documented the home would refuse to take the resident back to the home, once the resident was sent to the hospital for the assessment, based on the resident's current responsive behaviours. The ADOC documented they felt the resident was a risk to others and the home had exhausted interventions. On a specific date, the family physician transferred the resident for an assessment to the hospital. Further documentation identified the resident's SDM called and spoke with the ADOC requesting the reasons why the resident had been sent for the assessment.

Interview with the SDM confirmed they were surprised and upset when they were notified of the resident's discharge from the home at the same time they received notification that the resident had been transferred for an assessment. The SDM confirmed they were aware of ongoing communications regarding treatment for resident #001's behaviours and a potential placement to another unit. The SDM stated they were the resident’s SDM and they had not been kept informed and given the opportunity to participate in the discharge planning on the specified date in 2016, and that their wishes had not been taken into consideration.

Interview with the DOC confirmed that no meeting had occurred with the SDM to discuss the resident's discharge in 2016. The DOC confirmed communication occurred with the SDM, regarding the resident's ongoing responsive behaviours and potential for future placement, but had not included their participation or wishes regarding the resident's discharge at the same time they were being sent for an assessment. The DOC stated the home's practice would have been to wait for the recommendations from the treating provider, after the assessment period, and determine if the home could manage the

resident's responsive behaviour at that time. The DOC confirmed the licensee should not have discharged the resident at the time the resident was being sent for an assessment and had not collaborated with the appropriate placement coordinator and other health service organizations prior to the resident's discharge.

The BSO documentation in 2016, indicated they were notified after the resident had been sent for an assessment and that the home would not be accepting the resident back.

Interview with Community Care Access Centre (CCAC) Case Manager (CM) confirmed the CCAC was notified of resident #001's discharge from the home one day after the resident's discharge. The CM confirmed they had been in touch with the home on several occasions prior to the discharge regarding the resident's responsive behaviours and had been looking and waiting for another bed, on a different unit, at the home or another long term care home. The CM confirmed the discharge was not in collaboration with the CCAC and the CM had not spoken with the SDM, SMHO or the DOC regarding the intent to discharge the resident on the specified date in 2016. Interview with the SDM indicated the SDM had not wanted the resident to return to the home after discharge so placement was sought at another LTCH. [s. 148. (2)]

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 before a resident was discharged under subsection 145(1), there is b) collaboration with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care and secure environment required by the resident, c) that the resident and the resident's substitute decision maker, are kept informed and given opportunity to participate in the discharge planning and that their wishes are taken into consideration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record was kept up to date at all times.

Resident #001 was admitted to the home in 2016 with cognitive impairment. A review of the admission note, located in the clinical record, indicated the resident required extensive assistance with their activities of daily living. They had a history that included some responsive behaviours, prior to admission, that had been easily redirected and documented as diminished with medication changes. The home's social worker indicated assistance would be required with the resident's transition into the Long Term Care home. Recreation activities the resident had enjoyed were identified in the admission note.

On admission, the resident demonstrated behaviours when approached for care. A review of the discharge letter indicated the resident's behaviours continued to increase from the resident's date of admission to their discharge and they had not responded to interventions implemented in the home. However, a progress note completed by a Registered Practical Nurse indicated the resident was provided with an intervention that was described as effective and the nurse indicated that the resident should be offered this intervention when they demonstrated a responsive behaviour. This intervention was to be monitored for effectiveness to see if it would be effective in reducing the resident's responsive behaviour. There was no documentation that this intervention had been included in the resident's written plan of care.

Interview with staff #133 confirmed that the resident had been taken to a few 'group' based programs, which they refused, and was removed from the program due to escalated responsive behaviours. Staff #133 further identified that the resident attended

a music program and gardening which resulted in resident #001's responsive behaviours to be absent. Staff #133 confirmed the resident's written record, specifically the written plan of care, was not updated until after the resident's discharge to reflect the resident's care needs for attending recreation programs.

A review of the clinical record indicated the resident’s plan of care, in Point Click Care, included caregiver activities that had been initiated and created two days after the resident’s discharge.

Interview with the DOC confirmed the resident written plan of care was updated after the resident had left the home in 2016 and the licensee had failed to ensure the resident's written record was kept up to date at all times. [s. 231. (b)]

Issued on this 28th day of October, 2016

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

Original report signed by the inspector.