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
Feb 6, 2017	2016_542511_0017	029953-16, 030670-16, 032719-16	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): November 30, 2016, December 1, 6 and 9, 2016

The following Intakes were completed with this Inspection, #029953-16 related to whistle blower protection, #030670-16 related to a continence care and #032719-16 related to meal service planning and provision.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care (DOC), Admissions and Social Services Coordinator (ASSC), Personal Support Workers (PSWs), Registered Nurse (RN) and Registered Practical Nurse (RPN), resident and resident's family member. During the course of this inspection the Inspector observed the provision of resident care, meal service, reviewed applicable clinical records and applicable home's policy and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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's Substitute Decision Maker (SDM) had stated on interview that the resident had missed meals on a specified date when the resident had not been taken to the dining room for their meal. A review of resident #001's most recent plan of care indicated the resident was to be encouraged to come to the dining room for meals and the SDM had expressed their wishes for the resident to be in the dining room for all meals to promote socialization.

On an identified date in December 2016, the Long Term Care Inspector observed the resident to be absent from the breakfast meal service. Resident #001 was further observed to be in their bedroom, sitting upright in their chair at 0930 hours, with the bedroom light offs. The resident's eyes were closed. Interview with PSW #112 stated they had not approached the resident, to let them know it was breakfast, as they thought the resident was sleeping. PSW #112 stated the care needs of the resident were to not be approached if they were sleeping and they were to be brought a meal tray later in the day when they woke up. The PSW accessed the plan of care at approximately 0945 hours and confirmed they had not provided the care as set out in the plan of care when they had not encouraged the resident to attend the dining room for their breakfast.

On direction from RPN #112, PSW #112 was observed to encourage resident #001 to attend the dining room at 1000 hours after the breakfast meal service had finished. RPN #112 stated that the resident was to be encouraged to attend the dining room for meals

and that the licensee had failed to ensure that the care set out in the plan of care was provided to the resident when PSW #112 had not encouraged the resident to attend the meal service at 0900 hours. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #102 was observed on an two identified days in December 2016 at approximately 1000 hours to be sleeping in their bed with no meal tray at their bedside when the breakfast meal service was completed. A review of the clinical record identified the resident had been admitted in 2013. In November 2016, the quarterly Minimum Data Set assessment indicated the resident was at a nutrition risk due to having mostly refused meals at breakfast and choosing to sleep. Interview with PSW #114 and RPN #115 stated the resident's normal routine and preference was to sleep until approximately 1000 hours and the resident would be provided with a muffin, banana and yogurt when they awakened. A review of the resident's most recent plan of care indicated the resident ate their meals in the dining room. The last edited date for this intervention was January 2013. Interview with the documentation RPN #113, confirmed the resident previously went to the dining room in the morning for breakfast and that their care needs had changed when they refused or slept through the breakfast meal service. RPN #113 stated the plan of care had not been updated when the resident' s care needs changed. [s. 6. (10) (b)]

Issued on this 6th day of February, 2017

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

Original report signed by the inspector.