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
Mar 2, 2017	2016_542511_0018	027279-16, 027391-16, 030982-16, 032574-16	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): December 14, 15 and 16, 2016.

During this inspection the following complaints were inspected: 027391-16 (staffing) , 030982-16 (medications/plan of care) and 032574-16 (staffing/medication management), 027279-16 (medication management) . The following inquiries were also completed during this inspection: 030796-16 (RN Agency staffing), 034695-16 (PSW staffing), 030921-16 (Staffing).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Nursing Department Assistant Manager, Resident Assessment Instrument (RAI) Coordinator, Manager and Nurse Consultant (NC) for Assured Care Consulting, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Agency RN and Agency Supervisor, Pharmacy staff and residents.

During the course of this inspection the Inspector observed the provision of resident care, meal service, medication administration and reviewed applicable clinical records and home's policy and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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.

A review of the clinical records, for resident #002, outlined the resident was cognitively impaired and received an identified treatment for a noted condition on a date in 2016, when they had a change in their condition. Registered Nurse (RN) #116 was identified as the nurse responsible for resident #002's care needs, on the identified date in 2016. RN #116 was interviewed and described they had been notified by a PSW that resident #002 had a change in their condition. RN #116 stated they went to see the resident immediately, assessed the resident and administered a treatment for the condition. The resident was described to have minimal effect from the treatment administered by the RN and was transferred to hospital.
A review of the resident's plan of care identified the resident was to receive a different treatment, as prescribed, for the specified condition. The Electronic Medication record (eMar) indicated, as part of the medical directive, a treatment for the resident's specified condition.
Interview with RN #116 stated they were unaware of resident #002's prescription for treatment for the resident's noted condition. RN #116 confirmed they had not provided care to the resident, as specified in the plan of care and as part of the medical directive, for treatment of resident #002's condition in 2016.

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. 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with Regulation 114, (2) the licensee shall ensure written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's identified policy directed the staff to monitor for signs and symptoms and provided directions for the treatment of a specified condition.

RN #116 stated they had no knowledge of the treatment outlined in the home's policy and stated they were unaware the home had a policy for the specified condition. Interview with the DOC confirmed RN #116 had not implemented the home's policy for resident #002, when they experienced a change in their condition, on an identified date in 2016. [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 where the Act or this Regulation require the licensee of a long-term care home to have, instituted 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for (a) a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and this regulation.

During an observation on a home area, on an identified date in 2016, five residents; #003, #005, #006, #007, #008, were observed to not have their personal care completed. The residents did not appear to be distressed. On further observation, with RPN #118, the residents were confirmed to have not had their personal care needs met, by an identified time.

Interview with PSW #112 and #117 confirmed they had not provided the identified residents care, as set out in the plan of care, nor had they provided a meal to the identified residents by an identified time. The two PSWs stated they had run out of time, due to being short staffed, and were required to be in the dining room at the required time to assist other residents with their meal. The two PSWs stated that, after the meal service, they had planned to return to the remaining five residents (#003, #005, #006, #007, #008) to provide their care and provide them each a banana, muffin and drink for their meal. The two PSWs confirmed they had reported to RPN #118 their inability to provide the required personal care to the identified residents at the identified time.

Interview with RPN #118 confirmed that two PSWs, #112 and #117, had reported that they were unable to complete the personal care of the identified five residents as a PSW staff member had gone home on an identified date in 2016 and was not replaced. Interview with RPN #118 stated they had been notified, on the identified date in 2016, that a PSW staff member, scheduled to work, was unable to work their scheduled shift and went home. RPN #118 reported to RN #119, the RN identified responsible for the floor, the staffing concern and requested replacement staff. RPN #118 stated they were notified that a replacement staff would not be provided. Interview with RN #119 confirmed they were notified by RPN #118 that the unit was short staffed and required assistance. RN #119 stated the scheduled shift was required for personal care and assistance with meal service. RN #119 stated they notified the staffing scheduler and had been informed that the scheduled shift would not be replaced. RN #119 informed RPN #118 of the direction not to replace the staff and went directly to another home unit to provide medication administration due to a nursing staffing shortage on another floor.

Interview with the DOC confirmed the scheduled staffing assignment, for a PSW required for a scheduled shift on an identified home area, was not replaced on the identified date in 2016. The DOC further confirmed they had received previous communications and documented correspondence in the previous month, from registered staff on the home area, of the increased care needs for the identified residents. The DOC stated they directed the staffing scheduler not to replace the identified PSW shift on an identified date in 2016. The DOC further stated they had not provided direction to staff for the

prioritizing of tasks, to support the residents' provision of care, when the shift had not been replaced. Examples that were discussed with the Inspector but not conveyed to front line staff were: delay of making of resident beds and resident showers to later in the day, obtaining PSW assistance from another floor, utilizing other staff for assistance with transporting or dining so the PSWs could continue with morning care. The DOC confirmed the staffing mix, that was consistent with the residents' assessed care and safety needs, had not met the requirements set out in the Act and this regulation on December 16, 2016. [s. 31. (3) (a)]

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 staffing plan provided for (a) a staffing mix that is consistent with residents' assessed care and safety needs and that meet the requirements set out in the Act and this regulation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

A) On an identified date in 2016, at approximately 1020 hours, resident #005 was observed awake in their bed and in their sleep wear. The two PSWs confirmed resident #005 required two staff to assist with getting the resident up, dressed and transferred into their chair.

B) On an identified date in 2016, at approximately 1020 hours, resident #006 was observed in their bed and in a hospital gown. The two PSWs confirmed the resident #006 required two staff to assist with hygiene, grooming and were unable to get the resident dressed in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear on the identified date 2016.

C) On an identified date in 2016, at approximately 1020 hours, resident #007 was observed in their bed, in their sleep wear. The two PSWs confirmed the resident #007 required two staff to assist with care and were unable to get the resident dressed and up into their chair for their meal due to the staffing complement.

D) On an identified date in 2016, at approximately 1020 hours, resident #008 was observed in their bed, in their sleep wear. The two PSWs confirmed resident #008 had a condition that required two staff for extensive assistance with care. The two staff stated they had been unable to get the resident dressed and up into their chair for their meal due to the staffing complement.

Interview with PSW #112, and PSW #117 stated they were short staffed as the unit was missing a regularly scheduled PSW shift on an identified date in 2016.

Interview with the DOC confirmed the home had not replaced the shift and the licensee had failed ensure that resident #005, #006, #007, #008 were dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear on the morning of December 16, 2016. [s. 40.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that, (g) residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

A) On an identified date in 2016, at approximately 1020 hours, resident #006 was observed in their bed, in a hospital gown with their incontinence product unchanged. The most recent plan of care indicated the goal was to keep the resident clean dry and odor free and the resident was to be toileted at identified times.

B) On an identified date in 2016, at approximately 1020 hours, resident #007 was observed in their bed with their incontinence product unchanged. The most recent plan of care indicated the resident wore a brief and was on a continence program which required the resident to be toileted at identified times. The most recent plan of care indicated staff were to introduce themselves, explain what they were going to do and keep communication simple. Interview with PSW #112, and PSW #117 stated they were short staffed on the unit on an identified date in 2016, and had been trying to get other residents to the dining room. The two PSWs confirmed resident #007 required two staff to assist with toileting and required the staff to move slowly and calmly. The two PSWs stated they had been unable to toilet or change the resident's continence product, as specified in the plan of care.

C) On an identified date in 2016, at approximately 1020 hours, resident #008 was observed in their bed, in their sleep attire with their incontinence product unchanged. The most recent plan of care indicated the goal was to keep the resident clean dry and odor free and the resident was to be toileted at identified times. The two PSWs confirmed resident #008 required two staff to assist with toileting and had not toileted or changed the resident's continence product, on the identified date and time, in an effort to have the resident remain clean, dry and comfortable.

Interview with PSW #112 and PSW #117, stated they were short staffed as the unit was missing a regularly scheduled PSW shift and were unable to provide the continence care needs of the residents described above on an identified date and time.

RPN # 118 observed the residents' care status with the Inspector and confirmed the identified residents had been incontinent and had not had their continence product changed as directed in the plan of care and based on the residents' assessed needs. RPN #118 stated they had notified RN #119 that the PSWs were unable to complete the personal care of the identified residents because a PSW staff member had gone home on an identified date in 2016, and had not been replaced.

Interview with the DOC confirmed the home had not replaced the PSW shift and the licensee had failed to ensure that resident #006, #007 and #008, who required continence care products, had sufficient changes to remain clean, dry and comfortable on the morning of December 16, 2016. [s. 51. (2) (g)]

Issued on this 3rd day of March, 2017

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

Original report signed by the inspector.