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
May 18, 2017	2017_587129_0003	027053-16, 001008-17, 004564-17	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

PHYLLIS HILTZ-BONTJE (129)

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): February 28, March 30 and 31, 2017

The following logs where inspected during this inspection: Log #004564-17 related to personal care, Log #001008-17 related to personal care and Log #027053-16 related to abuse prevention.
A Critical Incident Inspection #2017_587129_0002 and a Follow Up Inspection #2017_587129_0005 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, resident's family members, Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Physiotherapist, the Director of Care (DOC), the Nurse Consultant, the Admissions Social Services Coordinator, the Nursing Unit Clerk and the Administrator.
During this inspection the inspector reviewed clinical records, personnel records, information related to complaints the home had received, the Abuse Prevention Policy, staffing schedules, e-mail communication from a complainant as well as e-mails maintained by staff in the home.
During this inspection the inspector observed care that was provided to a resident.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001's Substitute Decision Maker (SDM) was not given the opportunity to participate fully in the development and implementation of the resident's plan of care when staff administered medications to the resident that had not been approved by the SDM.
On an identified date in 2017 the resident's physician order a change in three medications the resident had been receiving and also ordered two additional medications. The physician's order was prefaced by "If the POA agrees with the following". The SDM and the clinical record confirmed that the staff in the home communicated with the SDM about the proposed medication changes on the day the physician wrote the orders, at which time the SDM provided direction that no medications were to be changed until the SDM had reviewed the proposed changes. A review of the Medication Administration Record (MAR) for the above noted period of time confirmed that the day after the physician wrote the above noted order staff administered one of the additional medications and also administered one of the medications that was ordered to be given at a reduced dosage, neither of which the SDM had approved.

(PLEASE NOTE: This non-compliance was identified during an inspection of Log #004564-17) [s. 6. (5)]

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 and ensuring that the resident, the resident's substitute decision maker, if any, and any other person designated by the resident or substitute decision marker are given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Registered staff #168 and the clinical record confirmed that resident #001 was not bathed a minimum of twice a week. Resident #001's plan of care provided directions to staff related to bathing and alternatives to bathing. During the monitored period in March 2017, the resident was to receive eight scheduled baths/showers/alternatives. Registered staff #168 and the clinical record confirmed that the resident had not received a bath/shower/alternative on three of the identified scheduled dates during the monitored period of time and also confirmed that a bath/shower/alternative had not been provided to the resident prior to the next scheduled baths during this period of time. [s. 33. (1)]

Issued on this 26th day of May, 2017

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

Original report signed by the inspector.