Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2019	2019_569508_0028	016633-19	Complaint

Licensee/Titulaire de permis

Chippawa Creek Care Centre Ltd.
c/o Park Place Seniors Living Inc. 20 Adelaide Street East, Suite 303 TORONTO ON M5C 2T6

Long-Term Care Home/Foyer de soins de longue durée

Bella Senior Care Residences
8720 Willoughby Drive NIAGARA FALLS ON L2G 7X3

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

ROSEANNE WESTERN (508)

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): October 18, 22, 23, 24, 2019.

Complaint intake, log # 016633-19 was inspected related to resident care concerns.

Please note: This inspection was conducted concurrently with a Critical Incident inspection #2019_569508_0029.

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures, the 2019 complaint log and discharged resident records.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, Behavioural Support of Ontario (BSO) Team Lead, registered staff and Personal Care Providers (PCP)s.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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 has failed to ensure that the resident's substitute decision-maker (SDM) and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director related to not informing the SDM of changes in the plan of care for resident #001.

Resident #001 was admitted to the home on an identified date in 2019. Resident #001 was cognitively impaired and had appointed their spouse as their SDM.

On an identified date in 2019, progress notes and the physician's order form indicated that resident #001 was ordered two medications.

Documentation indicated that the change in the one medication had been discussed with the SDM and consent had been obtained; however, there was no documentation to verify that the implementation of the other medication had been discussed with the SDM.

Staff #108 indicated that the physician had discussed starting the resident on medication; however, there was no documentation that could confirm that this occurred. The physician's order form indicated that consent had been obtained for one of the medication but not the other. The SDM indicated during a conversation with this inspector that they were unaware of the change.

It was confirmed during review of the resident's clinical records and during interview with the ADOC that the resident's substitute decision-maker (SDM) and any other persons designated by the resident or SDM were not given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

WN #2: 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 has failed to ensure that any actions taken with respect to a resident under a program was documented.

During a complaint inspection, the complainant had reported concerns related to the bathing for resident #001. During this inspection, the inspector reviewed the bathing documentation for resident #001 over an identified period. The documentation indicated that the resident only received one bath over this 30 day period.

During interviews with PCP staff #107, they indicated that they worked full time on the resident's unit and resident #001 was scheduled for baths on most of their shifts and that the resident received their two baths per week. Registered staff #110 who worked full time on the same unit confirmed this information.

During interview with the RAI-Coordinator, they confirmed that the documentation of care provided to the residents is not always being documented due to work load and that this issue had already been identified by the home. Further discussion with PCP #107 indicated that they often don't have time to document all the care provided to the residents.

It was confirmed during record reviews and during interviews that actions taken with respect to a resident under a program had not been documented. [s. 30. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up required.

A complaint was submitted to the Director related to care concerns of resident #001. During this inspection, the inspector requested the 2019 complaint log to review these complaints as the complainant indicated that these care concerns were discussed with the DOC and the Administrator.

During review of the 2019 complaint log, it was identified that the care concerns discussed with the Administrator and DOC had not been documented in the log. The Administrator confirmed that they had met with the resident's Substitute Decision Maker (SDM) frequently; however, notes related to care concerns were documented in their note book but not in the complaint log.

Review of the notes taken during these discussions and review of the electronic resident record, identified that actions taken, including the date of the action, time frames for actions to be taken and any follow up required had not been documented.

It was confirmed during interview with the Administrator that a documented record was not kept in the home that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up required related to these concerns.

Issued on this 21st day of November, 2019

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

Original report signed by the inspector.