



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

**Rapport d'inspection
prévue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ième} étage
Hamilton ON L8P 4Y7

**Ministère de la Santé et des Soins de
longue durée**

Telephone: 905-546-8294
Facsimile: 905-546-8255

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
October 26, 2010	2010-165-2890-26Oct165046	Complaint H-02090

Licensee/Titulaire
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 Residence
8720 Willoughby Drive
Niagara Falls, ON
L2G 7X3

Name of Inspector(s)/Nom de l'inspecteur(s)
Tammy Szymanowski #165

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to residents receiving adequate levels of assistance during the supper meal.

During the course of the inspection, the inspector spoke with: the administrator, the director of care, nursing staff members, dietary staff members, and residents.

During the course of the inspection, the inspector: observed supper meal service and reviewed resident's clinical records.

The following Inspection Protocols were used during this inspection: Dining observation inspection protocol.

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)
Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg. 79/10, s.24(6)

The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan.

Findings:

1. The plan of care for an identified resident indicates that the home is to provide a specialized meal plan based on the resident's preferences however; a protein choice was not offered and provided to the resident. As a result, the resident received a jam sandwich for the supper meal October 26, 2010.
2. The plan of care for an identified resident indicates that the resident requires extensive assistance of one staff to assist with feeding as the resident will sometimes start but tires easily or loses focus due to cognitive impairment however; when the resident was served the supper meal on October 27, 2010, the resident immediately pushed the meal to the side. Assistance with eating was not offered to the resident until seventeen minutes after the resident's meal was provided and the resident did not consume any of their supper meal. The resident only consumed bites of the dessert with the encouragement and assistance from staff.
3. The plan of care for an identified resident indicates that the resident requires constant encouragement during meals however; the resident was only encouraged 2-3 times during the full supper meal October 26, 2010 and the resident only consumed bites of their meal. It is noted that a staff member was present at the table assisting another resident for the first ten minutes of the meal however; constant encouragement was not provided during this time.

Inspector ID #: 165

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 with ensuring that the care set out in the care plan 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. 71(4)

The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Findings:

- The home did not have an individualized menu item prepared and available for an identified resident during the supper meal October 27, 2010. The home offered to prepare an item for the resident after meal service began however; the resident did not want to wait and as a result received a jam sandwich.

Inspector ID #: 165

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 with ensuring that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

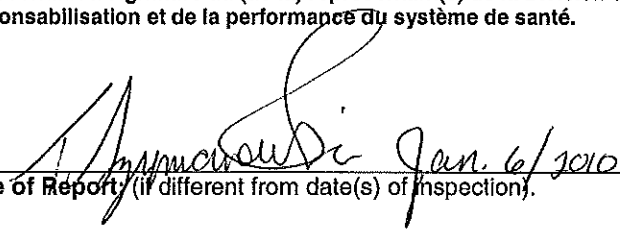
WN #3: The Licensee has failed to comply with O.Reg. 79/10, s. 73(2)

(b) The licensee shall ensure that, no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Findings:

- An identified resident did not receive assistance with eating their meal until twenty two minutes after their supper meal was served October 27, 2010.

Inspector ID #: 165

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.	
			
Title:	Date:	Date of Report (if different from date(s) of inspection).	
		Jan. 6/2010	