Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 12, 2021	2021_704682_0002	018807-20, 020195-20, 020428-20, 024898-20	Complaint

Licensee/Titulaire de permis

Chippawa Creek Care Centre Ltd.
c/o Bella Senior Care Residences 8720 Willoughby Drive Niagara Falls ON L2G 7X3

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

AILEEN GRABA (682), LESLEY EDWARDS (506)

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 3, 4, 5, 8, 9, 10, 11, 12, 16, 17, 18, 19, 22, 23, 24, 25 and 26, 2021.

The following Critical Incident intake was completed concurrently with the Complaint inspection:
001086-21 (2890-000001-21) related to hospitalization and change in condition

The following Follow up intake was completed concurrently:
020195-20 related to medication

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC), Associate Director of Care (ADOC), Resident Support Services Manager, Environmental Services Manager, Office Manager, Physiotherapist, Pharmacist, Restorative Care Aide, front entrance screeners, housekeeping, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP).

During the course of the inspection, the inspector(s) toured the home; reviewed investigative notes, staffing schedules, resident health records, meeting minutes, program evaluations, policies and procedures, complaints binder/logs, Critical Incident System (CIS) submissions; observed Infection Prevention and Control practices (IPAC), residents and provision of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 115. (1)	CO #001	2020_661683_0014	506

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 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 failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (2), and in reference to O. Reg. 79/10, s. 30 (1) 1, the licensee was required to have written procedures that included methods to reduce risk and monitor outcomes.

Progress notes identified that a Registered Practical Nurse (RPN) was called to assess a resident because they had sustained an injury. The RPN stated that they were not sure how the resident sustained the injury but reported the injury to the Registered Nurse (RN) for further follow up. The RN confirmed that they were made aware of the resident's injury, but that they did not investigate the incident, or develop any action plans to prevent reoccurrence. The Director of Care (DOC) was interviewed and they indicated they were not notified of the injury and did not participate in the investigation. Because the home did not perform an analysis/investigation into the incident to determine the source of the injury, preventative measures were not implemented and the resident was at further risk of harm and reoccurrence.

Sources: Electronic medical record, progress notes, Resident Safety Incident Investigation, Analysis and Remediation policy, Interviews with staff and the DOC. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (4) , and in reference to O. Reg. 79/10, s. 52 (1) 4 , the licensee was required to monitor resident's responses to and effectiveness of pain management strategies.

A) Progress notes indicated that the RPN identified a resident was experiencing pain during the provision of care. On a subsequent date, a different RPN also indicated that the resident was experiencing pain. The resident's electronic medication administration record (EMAR) identified that they were ordered an analgesic and that they were administered the medication.

The RPN confirmed that a comprehensive pain assessment should have been completed. Because the resident did not receive a comprehensive pain assessment as indicated in the home's pain management policy, the resident was at risk for inadequate pain management.

Sources: Electronic medical record, Pain Identification and Management policy, Interview with staff

B) An EMAR review identified that a resident was administered an analgesic. Progress notes identified that the resident was experiencing ongoing pain. No pain assessment was documented at the time for the resident.

The Associate Director of Care (ADOC) confirmed that a comprehensive pain assessment was not completed. Because the resident did not receive a comprehensive pain assessment as indicated in the home's pain policy, the resident was at risk for inadequate pain management.

Sources: Electronic medical record, Pain Identification and Management policy, Interview with ADOC and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.30 (1) 1, states the licensee shall ensure that in respect of the organized falls prevention and management program there must be a written description of the program that

includes relevant policies and that this is complied with.

A) A resident sustained unwitnessed falls. Head injury routine was initiated after both falls. The ADOC confirmed that the resident did not have all the assessments completed. A review of the clinical record confirmed the resident did not have all the assessments completed.

B) Two other co-resident's sustained a fall, where they did sustain an injury and it was confirmed through record review that all the assessments were not completed.

Interview with the DOC confirmed that the staff did not complete the post fall assessments as stated in the policy.

Not completing the post fall assessments including head injury routine as required, posed a risk to the resident as it may have resulted in staff missing any signs or symptoms of a head injury or changes in the resident's condition.

Sources: Clinical records including progress notes and head injury routine, interview with staff and the home’s policy for Fall Prevention and Management Program and Head injury routine [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that there was a written plan of care related to palliative care for a resident that sets out the planned care for the resident.

A resident was assessed and ordered palliative/end of life care. The care plan did not identify any comfort measures/ interventions to support the resident's end of life care needs.

The licensee's "Palliative Care Program" policy directed staff to develop and implement a palliative plan of care with individualized interventions, including but not limited to: disease and symptom management, communicating individualized interventions to staff and reviewing and revising the plan of care as needed.

A RPN stated in an interview that when a resident's health status changes to palliative, they inform the Administrator and DOC, communicate to staff via shift reports and document in the progress notes. The RPN confirmed that a written palliative plan of care that set out the planned care had not been developed and implemented to meet the resident's end of life care needs. By not developing a written palliative plan of care that

set out the planned care, the resident was at risk for not having their end of life care needs met.

Sources: Resident's care plan, progress notes, physician orders, Palliative Care Program policy, interviews with RPN and other staff. [s. 6. (1)]

2. The licensee has failed to ensure that there was a written plan of care for resident that set out the planned care for the resident.

A review of the resident’s clinical record confirmed that the resident was recently initiatetd a treatment by the physician. The treatment was reassessed, as the staff felt the treatment was not effective, they initiated another treatment. The treatment was not added to the resident’s treatment record or plan of care for when and how often to use the treatment. This information not being added to the plan of care with specific instructions at the time of the assessment posed a risk of staff not using the treatment as clinically indicated. The DOC confirmed that the planned care for the resident did not include specific instructions.

Sources: Resident's clinical record including physician orders, treatment assessment record and the written plan of care and interview with the DOC. [s. 6. (1) (a)]

3. The licensee has failed to ensure that there was a written plan of care for the resident that sets out clear directions to staff and others who provide direct care to the resident.

A resident returned from the hospital with a medical intervention in situ. The readmission order identified the medical intervention, however; there were no instructions. Interview with a RN confirmed that the resident’s plan of care did not provide clear direction to staff in relation to the medical intervention. Not having clear direction left the resident at risk for complications.

Sources: Resident's written care plan, treatment record, interview with RN. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A resident had physician’s order that directed registered staff to notify them if a certain parameter was met. A review of the clinical record identified that on two occasions the resident met the identified parameter and there was no documentation to confirm that the

physician was notified as per the plan of care.

The DOC confirmed that resident's plan of care was not followed by the staff with notifying the physician. In failing to not follow the resident's plan of care and notifying the physician, it did not allow for the physician to make any changes to the resident's plan of care.

Sources: Resident clinical record including physician's orders, medication administration records and progress notes and staff interviews. [s. 6. (7)]

5. 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 care set out in the plan had not been effective.

A resident had a physician's order that involved a medical intervention to be performed by registered staff. A review of the plan of care confirmed that the resident would often refuse the medical intervention. There was no documentation that the physician was called to inform them that the resident was refusing the medical intervention nor were there any revisions or changes made to the resident's plan of care.

The DOC confirmed that when the resident's plan of care was not effective that the plan of care was reviewed and revised.

Sources: Resident's clinical record including progress notes, medication administration records and staff interviews. [s. 6. (10) (c)]

6. The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A substitute decision maker (SDM) for a resident called and spoke to a RPN with concerns that the resident was having pain and whether a medical intervention was still required. A RPN told the SDM that they would need to consult with the physician.

Interview with a RPN confirmed that they did not call the physician and thought that the RN's would have called. Two RN's who both worked that day confirmed they did not call the physician either.

The licensee failed to review and revise the resident's plan of care when the family raised concerns regarding the care not being effective and the resident having complaints of pain.The risk to the resident for not reviewing and revising their plan of care was that the resident was not assessed for the need to ensure the intervention was still needed and effective.

Sources: Resident's clinical record including progress notes, and staff interviews. [s. 6. (10) (c)]

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 there is a written plan of care for each resident that sets out the planned care of the resident; to ensure clear directions to staff and others who provide direct care to the resident; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to 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 care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: 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 failed to ensure that a resident's intervention and the resident's responses to the intervention were documented.

Progress notes identified a resident had a change in condition, the physician was notified and initiated a medical intervention. A review of a resident's care plan and electronic treatment and medication administration records (ETAR, EMAR) did not include any documentation related to the intervention.

In an interview, a RPN stated that the resident had the medical intervention intermittently and that the intervention was usually documented in the care plan as well as the ETAR. The RPN confirmed that the resident's medical intervention was not documented.

By not documenting the intervention and monitoring the resident's responses, the resident was placed at risk for not receiving the safe delivery of the medical intervention.

Sources: Resident electronic medical record, interview with RPN and other staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a physician or registered nurse in the extended class conducted a physical examination on each resident upon admission and annually thereafter, and produced a written report of the findings of the examination.

Review of three resident's clinical records confirmed that the residents had not had an annual physical exam on an identified date, and were due to have their next annual physical exam and these also had not been completed. Two resident's were admitted to the home and a review of the clinical record confirmed that the physician had not completed the physical examination medical assessment forms or had completed any progress notes to say they had visited the residents since the time of their admission.

The ADOC confirmed, that the annual and admission physicals were not completed by the physician for the above residents. Not completing and documenting the required admission and annual physical examinations of resident's increases the risk that medical issues of resident's would go unidentified and unmanaged.

Sources: Resident's clinical records, physical examination and medical assessments, progress notes and interview with the ADOC. [s. 82. (1) (a)]

2. The licensee has failed to ensure that the physician attended regularly at the home to

provide services.

The DOC and Administrator confirmed that one of the Physician’s in the home was currently providing medical care and had not entered the home regularly to provide medical services for an identified period of time.

A resident's Substitute Decision Maker (SDM) expressed concern that the physician was not attending the home regularly and only doing phone rounds. Several registered staff confirmed that the physician had not been to the units to complete rounds and assessments and that they were completing phone rounds.

A review of resident clinical records confirmed that the physician had not been into the home to see these residents.

The DOC and Administrator confirmed that they were not aware that the physician had not been completing their annual and admission physicals and thought maybe another physician was completing these for them as they worked together.

The risk for not having a physician attend the home regularly to assess residents increased the risk that medical conditions may go undiagnosed.

Sources: Interviews with resident's SDM, the Administrator, DOC and registered staff. [s. 82. (1) (b)]

3. The licensee has failed to enter into a written agreement under O. Reg 79/10, s. 83 with the Attending Physician.

The Administrator provided a copy of the Attending Physician Agreement, for a term of one year and had expired and there was not a current written agreement between the licensee and the physician.

Sources: Attending Physician Agreement and interview with the Administrator. [s. 82. (4)]

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 either a physician or registered nurse in the extended class conducted a physical examination of each resident upon admission and annually thereafter, and produced a written report of the findings of the examination; to ensure that the physician attended regularly at the home to provide services, including assessments; to ensure an appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they complied with paragraph 2 of section 24. (1) of the LTCHA related to reporting certain matters to the Director.

Section 24. (1) paragraph 2 of the LTCHA states that "a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident."

Furthermore, section 152. (2) of the LTCHA states that "where an inspector finds that a staff member has not complied with subsection 24. (1) or 26. (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate."

As per section 2. of the Ontario Regulation 79/10, physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain.

The licensee's prevention of abuse policy directed the Administrator/ Designate to:
2. "Immediately initiate investigation of the alleged, suspected or witnessed abuse
5. Complete province-specific reporting form: c. Ontario LTC Critical Incident Reporting form".

According to correspondence between resident's SDM and the Administrator, the SDM alleged abuse. The Administrator confirmed that the allegations of harm made by the SDM were not reported to the Director.

Sources: The Administrator's correspondence, Zero tolerance of Resident Abuse and Neglect: Response and Reporting Policy, Interviews with the Administrator [s. 24. (1)]

WN #6: 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 failed to ensure that a resident was assisted with getting dressed as required, and was dressed appropriately.

According to a complaint, a resident was inappropriately dressed, and the substitute decision maker (SDM) reported their concern to a RPN. The resident's care plan identified that they required assistance of staff to dress and also refused care. Interventions were in place to respond to their resistance. Progress notes on an identified date, did not include any documentation that the resident was resistive to care or whether staff implemented any interventions in response to the resident's resistance to care.

The RPN was interviewed and confirmed that on an identified date the SDM did report the concern to them and confirmed that the resident was not appropriately dressed.

Sources: Resident electronic medical record, complaint, Interviews with RPN and DOC. [s. 40.]

WN #7: 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,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(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;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Correspondence was sent by a resident's SDM to the Administrator, identifying care concerns related to a resident. A review of the complaint log/binder was reviewed and no documentation was found regarding the nature of the concern/complaint, any actions taken or any responses provided to the SDM.

The licensee's "Complaints and Customer Service" policy directed the Administrator/Designate to initiate an investigation into the circumstances leading to the complaint within 24 hours; take notes of all interview questions, observations and other actions related to the investigation and record each contact with the complainant on the contact log.

The Administrator confirmed in an interview that they did not document any actions or responses in the home's complaint log/binder in relation to the concerns by the resident's SDM.

Sources: Correspondence from resident's SDM, Complaint and Customer Service Policy, interview with Administrator. [s. 101. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 214. Medical Director

Specifically failed to comply with the following:

s. 214. (1) Every licensee of a long-term care home shall enter into a written agreement with the Medical Director for the home that provides for at least the following:
1. The term of the agreement. O. Reg. 79/10, s. 214 (1).
2. The responsibilities of the licensee. O. Reg. 79/10, s. 214 (1).
3. The responsibilities or duties of the Medical Director under clause 72 (3) (b) of the Act, as set out in subsection (3). O. Reg. 79/10, s. 214 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written agreement with the Medical Director.

The Administrator provided a copy of the Medical Director Agreement which identified that the agreement was made on an identified date, for a one year term following that date. The written agreement between the licensee and the Medical Director expired and there was not a current written agreement between the licensee and the Medical Director.

Sources: Expired medical director agreement, interview with the Administrator. [s. 214. (1) 1.]

Issued on this 31st day of March, 2021

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	AILEEN GRABA (682), LESLEY EDWARDS (506)
Inspection No. / No de l’inspection :	2021_704682_0002
Log No. / No de registre :	018807-20, 020195-20, 020428-20, 024898-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 12, 2021
Licensee / Titulaire de permis :	Chippawa Creek Care Centre Ltd. c/o Bella Senior Care Residences, 8720 Willoughby Drive, Niagara Falls, ON, L2G-7X3
LTC Home / Foyer de SLD :	Bella Senior Care Residences 8720 Willoughby Drive, Niagara Falls, ON, L2G-7X3
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Veronica Swartz

To Chippawa Creek Care Centre Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 8. (1).

Specifically, the licensee must:

1. Ensure that an identified resident has a comprehensive pain assessment for any new pain in addition to the use of the pain assessment in advanced dementia (PAINAD) scale.

2. Ensure that an identified resident has a comprehensive pain assessment for 72 hours on the day, evening shifts and on night shift when awake for the following indications:
i. a new pain medication is started
ii. breakthrough pain medication is used for 3 consecutive days.

3. Ensure that any resident injury of an unknown source is thoroughly investigated with appropriate action plans to prevent reoccurrence.
i. Maintain written documentation including the details of the investigation and any actions taken upon conclusion of any resident safety investigation(s) related to a resident's injury.
ii. Include who will be responsible for maintaining records and evaluating the results of the investigations.

4. Ensure that two identified residents have head injury routines initiated hourly for four consecutive hours and then every eight hours for 72 hours post fall or as per current policy with any unwitnessed fall or when otherwise clinically indicated.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (2), and in reference to O. Reg. 79/10, s. 30 (1) 1, the licensee was required to have written procedures that included methods to reduce risk and monitor outcomes.

Progress notes identified that a Registered Practical Nurse (RPN) was called to

assess a resident because they had sustained an injury. The RPN stated that they were not sure how the resident sustained the injury but reported the injury to the Registered Nurse (RN) for further follow up. The RN confirmed that they were made aware of the resident's injury, but that they did not investigate the incident, or develop any action plans to prevent reoccurrence. The Director of Care (DOC) was interviewed and they indicated they were not notified of the injury and did not participate in the investigation. Because the home did not perform an analysis/investigation into the incident to determine the source of the injury, preventative measures were not implemented and the resident was at further risk of harm and reoccurrence.

Sources: Electronic medical record, progress notes, Resident Safety Incident Investigation, Analysis and Remediation policy, Interviews with staff and the DOC. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (4) , and in reference to O. Reg. 79/10, s. 52 (1) 4 , the licensee was required to monitor resident's responses to and effectiveness of pain management strategies.

A) Progress notes indicated that the RPN identified a resident was experiencing pain during the provision of care. On a subsequent date, a different RPN also indicated that the resident was experiencing pain. The resident's electronic medication administration record (EMAR) identified that they were ordered an analgesic and that they were administered the medication.

The RPN confirmed that a comprehensive pain assessment should have been completed. Because the resident did not receive a comprehensive pain assessment as indicated in the home's pain management policy, the resident was at risk for inadequate pain management.

Sources: Electronic medical record, Pain Identification and Management policy, Interview with staff

B) An EMAR review identified that a resident was administered an analgesic. Progress notes identified that the resident was experiencing ongoing pain. No pain assessment was documented at the time for the resident.

The Associate Director of Care (ADOC) confirmed that a comprehensive pain assessment was not completed. Because the resident did not receive a comprehensive pain assessment as indicated in the home's pain policy, the resident was at risk for inadequate pain management.

Sources: Electronic medical record, Pain Identification and Management policy, Interview with ADOC and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with Ontario Regulation 79/10 s. 48 (1) 1 and in reference to O. Reg s.30 (1) 1, states the licensee shall ensure that in respect of the organized falls prevention and management program there must be a written description of the program that includes relevant policies and that this is complied with.

A) A resident sustained unwitnessed falls. Head injury routine was initiated after both falls. The ADOC confirmed that the resident did not have all the assessments completed. A review of the clinical record confirmed the resident did not have all the assessments completed.

B) Two other co-resident's sustained a fall, where they did sustain an injury and it was confirmed through record review that all the assessments were not completed.

Interview with the DOC confirmed that the staff did not complete the post fall assessments as stated in the policy.

Not completing the post fall assessments including head injury routine as required, posed a risk to the resident as it may have resulted in staff missing any signs or symptoms of a head injury or changes in the resident's condition.

Sources: Clinical records including progress notes and head injury routine, interview with staff and the home's policy for Fall Prevention and Management Program and Head injury routine [s. 8. (1) (b)]

An order was made by taking the following factors in account:

Severity: There was risk for harm, potential for clinical deterioration and ineffective pain management when the home did follow their policies for head injury routine, pain management and incident investigation.

Scope: The scope was a pattern because six out of nine residents did not have comprehensive pain assessments, head injury routine or incident investigation when indicated.

Compliance History: One voluntary plan of correction (VPC) was issued to the home related to the same section of legislation in the past 36 months. (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 01, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of March, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Aileen Graba

Service Area Office /
Bureau régional de services : Hamilton Service Area Office