Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 10, 2024
Inspection Number: 2024-1375-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Chippawa Creek Care Centre Ltd.
Long Term Care Home and City: Bella Senior Care Residences, Niagara Falls

Lead Inspector	**Inspector Digital Signature**
Carla Meyer (740860)	Paola C Meyer Digitally signed by Paola C Meyer Date: 2024.06.18 10:42:12 -04'00'

Additional Inspector(s)
Emily Robins (741074)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15, 16, 18, 22-24, 26, 29, 30, 2024 and May 1-3, 6, and 10, 2024.

The inspection occurred offsite on the following date(s): May 1, 8, and 9, 2024.

The following intake(s) were inspected:

- Intake: #00110050 - [Follow-up] - Compliance Order (CO)#001 Responsive Behaviors.
- Intake: #00110048 - [Follow-up] - CO#002 Requirements on licensee before discharging a resident.
- Intake: #00110049 - [Follow-up] - CO#003 Requirements on licensee before discharging a resident.

- Intake: #00106289 - [Critical Incident (CI): 2890-000003-24] – Falls prevention and management
- Intake: #00108113 - [CI: 2890-000004-24] – Prevention of abuse and neglect.
- Intake: #00111115 - [CI: 2890-000007-24] – Infection prevention and control.
- Intake: #00111525 - [CI: 2890-000008-24] – Infection prevention and control.
- Intake: #00114222 - [CI: 2890-000012-24] – Infection prevention and control.
- Intake: #00112149 - [CI: 2890-000010-24] related to resident to resident abuse.
- Intake: #00114413 - [CI: 2890-000013-24] - related to an unexpected death of a resident.
- Intake: #00110249 - Complaint regarding plan of care.
- Intake: #00114462 - Complaint related to resident care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1375-0001 related to O. Reg. 246/22, s. 58 (3) (a) inspected by Carla Meyer (740860)

Order #002 from Inspection #2024-1375-0001 related to O. Reg. 246/22, s. 161 (2) (c) inspected by Carla Meyer (740860)

Order #003 from Inspection #2024-1375-0001 related to O. Reg. 246/22, s. 161 (2) (d) inspected by Carla Meyer (740860)

The following **Inspection Protocols** were used during this inspection:

Admission, Absences and Discharge
Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Palliative Care
Prevention of Abuse and Neglect
Responsive Behaviours
Resident Care and Support Services
Residents' and Family Councils
Whistle-blowing Protection and Retaliation

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

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

Rationale and Summary
A resident was able to use the toilet independently but required supervision for transfer out of bed. On an identified date in January of 2024, this resident

independently transferred out of bed to use the washroom and subsequently slipped and fell and sustained an injury.

Staff indicated that this resident was known to attempt to transfer out of bed independently at times and was to have a bed alarm in place. The resident's written plan of care at the time of the fall did not include a bed alarm, nor what type of footwear the resident was to wear as per their preferences.

Failure to ensure that the resident's written plan of care included these planned care items, may have increased their risk of a fall.

Sources: Resident's written plan of care and interviews with a PSW, and two RPNs.
[741074]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee failed to ensure that a resident's plan of care was complied with.

Rationale and Summary
A resident's clinical records indicated that they were seen by an external physician on an identified date in January of 2024 and their planned care was to remain at the home despite their current condition. These wishes were discussed by the home's Medical Director (MD) with the external physician, reviewed by the home and

approved by the MD.

The resident's progress notes showed that on an identified date in February 2024, the MD assessed the resident and together with the Infection Prevention and Control Lead (IPAC Lead) and Director of Care (DOC), discussed the need for the resident to be transferred to the hospital with the POA however, the POA declined. On the evening of the same date, the home attempted to have the resident transferred to the hospital without the POA's knowledge. The MD acknowledged that the need for the transfer to hospital was not related to a medical emergency.

By not following the resident's plan of care, the resident's wishes were not respected as per their orders.

Sources: Review of resident's clinical records, the home's policy titled "Advanced Care Planning," last updated November 2023, the home's policy titled "Informed Consent," last reviewed November 2023; and interview with the Coroner, Detective, the Assistant Director of Care (ADOC), the home's Physician, the IPAC Lead, RN , RPN, and the Administrator. **[740860]**

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that the staff and others who provided direct care to a

resident had convenient and immediate access to the contents of the resident's plan of care.

Rationale and Summary
On an identified date in March of 2024, a resident had an altercation with another resident. This resident had a history of frequent infections, as well as exhibited behaviours related to the infections. Direct care staff indicated that they access the resident's plan of care through the Kardex, which pulls through from the care plan.

These responsive behaviours and the interventions in place to manage them were not added to the resident's care plan/Kardex until a later specified date in March 2024.

Sources: Interviews with PSW's, RPN, Responsive Behaviours Lead, ADOC, the resident's progress notes, care plan, Kardex, and Risk Management. **[741074]**

WRITTEN NOTIFICATION: Consent

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7
Consent
s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent.

The licensee failed to ensure that they received consent from a resident's POA when the licensee attempted to transfer the resident to the hospital.

Rationale and Summary

On a specified date in February 2024, a resident's progress note showed that the home's Medical Director (MD), Infection Prevention and Control (IPAC) Lead, and Director of Care (DOC) had discussed the resident's condition with their POA outlining their assessed need to transfer the resident to the hospital. Despite the information provided by the home's team, the POA refused to have the resident sent to the hospital. The MD however acknowledged that transferring the resident to the hospital was not due to a medical emergency and that the POA ultimately had the right to refuse.

The home's staff and leadership team acknowledged that they were aware of the POA's wishes and refusal. According to the home's Administrator, despite querying directions given by authorities, the home contacted Emergency Medical Services (EMS) and after obtaining a verbal order from the MD, attempted to send the resident to the hospital without the POA's knowledge or consent.

The EMS contacted the POA upon their arrival to the home to obtain consent and the POA continued to refuse.

The home's policy titled "Informed Consent," last reviewed November 2023 stated that all residents or their Substitute Decision-Makers (or "proxies" or other term used in a given province) will provide informed consent prior to the initiation of all treatments/treatment plans.

In addition, the home's policy titled "Advanced Care Planning," last reviewed November 2023 noted that in Ontario, while residents may choose to make their wishes known regarding which approach to care they would like, staff must still obtain informed consent and provide the resident with all relevant and known information regarding possible treatment options, and allow the resident (or if

incapable, the SDM) to provide (or refuse) informed consent to treatment.

By attempting to transfer the resident against their POA's wishes, the resident's rights and wishes were negatively impacted.

Sources: Review of resident's clinical records, the home's policy titled "Advanced Care Planning," last updated November 2023, the home's policy titled "Informed Consent," last reviewed November 2023; and interview with the Coroner, Detective, the Assistant Director of Care (ADOC), the home's Physician, the IPAC Lead, RN, RPN, and the Administrator. **[740860]**

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of Ontario Regulation 246/22 defines physical abuse as “the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”)”.

Rationale and Summary
A resident had a physical altercation with a fellow resident when the resident attempted to take an item from another resident. This caused a temporary

discomfort and reddening of the skin to the fellow resident.

Failure to ensure a resident was protected from physical abuse by another resident resulted in actual harm.

Sources: Resident's clinical records, Risk Management incident, the home's zero tolerance of abuse and neglect policy, and interviews with a resident, PSW, and Assistant Director of Care (ADOC). **[741074]**

WRITTEN NOTIFICATION: Reports of investigation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee failed to ensure that the results of an investigation of abuse and neglect of a resident was reported to the Director.

Rationale and Summary
According to Ontario Regulations 246/22, s. 11 (1) (b), where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy and program, the licensee is required to ensure that the policy and program is complied with.

On a specified date in February of 2024, the home contacted the Ministry of Long-Term Care's after-hours line to report suspected abuse and neglect of a resident by a visitor. The home then submitted the Critical Incident (CI) report to the Director and

the Administrator acknowledged that this was submitted under the incorrect category and that the home's procedure for reporting suspected abuse should have been followed. The report indicated that a suspected abuse of a resident was determined and based on the incident, the Police and the Medical Director (MD) were notified. There were no amendments made to the report, nor were there any indication that the home followed up with an investigation. The home's Infection Prevention and Control (IPAC) Lead acknowledged that an investigation had not been conducted.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program," RC-02-01-01, last reviewed November 2023 stated that anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident; that the home must follow province-specific reporting requirements based on the Jurisdictional reporting Requirements Appendix 2.

Furthermore, the jurisdictional reporting requirements under appendix 2 of the home's program stated that results of the abuse/neglect investigation and any action(s) taken in response to the incident must be submitted by management within 10 days or earlier if requested, using the Critical Incident System (CIS).

By failing to report the results of the investigation of suspected abuse and neglect, it was uncertain that the home followed proper procedures which may have impacted their ability to protect the resident from abuse.

Sources: Interview with the Administrator, IPAC Lead, ADOC, and review of the home's Zero Tolerance of Resident Abuse and Neglect Program, last reviewed November 2023. **[740860]**

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary

On a specified date in April of 2024, a resident had an altercation with another resident resulting in this resident sustaining an injury, as witnessed by staff of the home. This incident was not reported to the Ministry of Long-term Care.

Sources: Interviews with ADOC, resident's progress notes, Risk Management.
[741074]

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:
1) Have a registered staff review the home's policy(s) or procedure(s) outlining the appropriate actions to be taken by nursing staff when a resident is exhibiting signs or symptoms of chewing and/or swallowing difficulty and;
3) Keep a record for inspector review of the date the above steps were completed with a signature from the staff indicating that they have completed the steps above.

Grounds
The licensee failed to ensure that the organized program of nutritional care and dietary services included the implementation of interventions to mitigate and manage risks related to nutritional care and dietary services for a resident.

Rationale and Summary
On an identified date in April 2024, a nursing staff indicated that they and other staff

members had observed a change in the resident.

The Registered Dietitian (RD) and the nursing staff indicated that due to this change a referral to the RD should have been initiated by a member of the nursing staff. They also indicated that nursing staff can temporarily implement interventions in the interim for safety purposes. No changes to the resident's interventions nor referrals to the RD were initiated. The nurse indicated that they should have referred the resident to the RD and provided the resident a modified intervention with their diet until further assessment could be completed.

On another specified date in April 2024 following the observed change, the resident was served a meal according to their diet texture as per their current diet order which resulted in an incident that led to the resident's death.

Failure to ensure that the appropriate interventions were implemented may have contributed to the resident's risk of choking. **[741074]**

Sources: Resident's progress notes, diet orders, RD referrals, and interviews with staff. **[741074]**

This order must be complied with by June 20, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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