



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

**Rapport d'inspection  
prévus 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

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Hamilton ON L8P 4Y7

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

Division de la responsabilisation et de la performance du  
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| <b>Date(s) of inspection/Date de l'inspection</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Inspection No/ d'inspection</b> | <b>Type of Inspection/Genre d'inspection</b> |
| October 26, 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 2010-165-2890-26Oct165046          | Complaint H-02090                            |
| <b>Licensee/Titulaire</b><br>Bella Senior Care Residences Inc.<br>1000 Finch Avenue West, Suite 901<br>Toronto, ON<br>M3J 2V5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                    |                                              |
| <b>Long-Term Care Home/Foyer de soins de longue durée</b><br>Bella Senior Care Residence<br>8720 Willoughby Drive<br>Niagara Falls, ON<br>L2G 7X3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                    |                                              |
| <b>Name of Inspector(s)/Nom de l'inspecteur(s)</b><br>Tammy Szymanowski #165                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                    |                                              |
| <b>Inspection Summary/Sommaire d'inspection</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                    |                                              |
| <p>The purpose of this inspection was to conduct a complaint inspection related to residents receiving adequate levels of assistance during the supper meal.</p> <p>During the course of the inspection, the inspector spoke with: the administrator, the director of care, nursing staff members, dietary staff members, and residents.</p> <p>During the course of the inspection, the inspector: observed supper meal service and reviewed resident's clinical records.</p> <p>The following Inspection Protocols were used during this inspection: Dining observation inspection protocol.</p> <p><input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken:</p> <p>3 WN<br/>2 VPC</p> |                                    |                                              |

## 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:**

1. 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:**

1. 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).