Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2015	2015_258519_0016	#004195-15	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE KITCHENER ON N2N 2A8

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

SHERRI GROULX (519)

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): April 21 and 22, 2015

This Complaint inspection involved looking at Hospitalization and Change in Condition and Pain.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, and an Assistant Director of Care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Pain
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff.

The plan of care for an identified resident indicated the resident had specific care needs related to responsive behaviours.

On a specified date after morning care was provided, a Personal Support Worker (PSW) responsible for the identified resident's care, transferred the resident into their wheelchair without the assistance of another staff member. The PSW did not provide care to this resident again until eight hours later when the resident was toileted with the assistance of another PSW.

According to the notes, this resident sat in their wheelchair in a specific area of the home until their family arrived later in the day. The PSW stated that they did not change the resident's brief and only changed the position of the wheelchair throughout the day.

The Executive Director and Director of Care confirmed that the PSW neglected the resident when the resident was left in their wheelchair for eight hours without care being provided. [s. 3. (1) 3.]

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 the following rights of residents are fully respected and promoted: Every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

According to a resident's progress notes, it was documented that a resident's family had an identified area of concern.

According to the home's notes, a Registered staff member was asked to assess the resident. The Registered Staff visualized the area and made a recommendation.

According to the home's notes, the evening shift Registered staff did an assessment of the area but did not document it or put it in the evening shift report.

According to the home's notes, the night shift Registered staff stated that the evening shift Registered staff verbally reported the information but stated it was nothing unusual. The night shift Registered staff did not assess the resident as this staff was told by the evening shift Registered staff it was nothing unusual. The night shift Registered staff could not recall if this information was shared with the day shift nurse the next day.

Upon interview with the Executive Director it was confirmed that the evening shift Registered staff did not do a proper assessment of the resident when the area of concern was just visualized and not physically assessed.

Upon interview with the Director of Care it was confirmed that as a result of the evening Registered staff not documenting the physical assessment the night shift Registered staff was not properly alerted to do their own assessment.

The licensee failed to ensure that staff involved in the different aspects of care collaborated with each other in the assessment of the resident. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting the resident.

On a specific date a resident was assigned to a Personal Support Worker (PSW) who was working the day shift.

According to the home's notes it was noted that the assigned PSW provided morning care to this resident while the resident was in bed.

When the PSW was ready to transfer the resident to his/her wheelchair the PSW transferred the resident on their own even though the resident was a two person transfer.

According to the care plan this resident required a two person transfer. In the home's notes, the PSW did not understand the importance of following the plan of care when transferring the resident.

On a specific date the Executive Director and the Director of Care confirmed that the PSW did not use safe transferring techniques when they transferred the resident independently, instead of using a two person transfer that was outlined in the resident's plan of care. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting the resident, to be implemented voluntarily.

Issued on this 12th day of May, 2015

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

Original report signed by the inspector.