Ontario

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

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 17, 2011	2011_170_2707_17May110501	Critical Incident L-000515

Licensee/Titulaire
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 Long-Term Care Centre, 60 Westheights Drive, Kitchener, ON N2N 2A8

Name of Inspector(s)/Nom de l'inspecteur(s)
Dianne Wilbee #170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to resident abuse.

During the course of the inspection, the inspector spoke with: Executive Director, Director of Care

During the course of the inspection, the inspector: Reviewed home's investigation, reviewed applicable policies and procedures, reviewed resident record, reviewed employee documents.

The following Inspection Protocols were used in part or in whole during this inspection:

- Prevention of Abuse, Neglect and Retaliation

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

6 WN
6 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 **LTCHA, 2007, S.O. 2007, c.8, s.23(2)** A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a).

Findings:
The Critical Incident Report submitted March 28, 2011 does not include the results of the home's investigation.

Inspector ID #:	170

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 all reporting requirements, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.24(1)2** 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.

Findings:
The critical incident occurred March 4, 2011 and the home indicated determination of resident abuse as of March 22, 2011. The critical incident report was not submitted to the Director until March 28, 2011.

Inspector ID #:	170

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 the reporting requirement, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with **O.Reg. 79/10, s.104(1)3v** In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

3. Actions taken in response to the incident, including,

v. the outcome or current status of the individual or individuals who were involved in the incident.

Findings:
The Critical Incident Report of March 28, 2011 does not indicate the status of the individual who was involved in the occurrence.

Inspector ID #:	170

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 related to including the status of the individual involved in the incident on the critical incident report, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with **O.Reg. 79/10, s.24(2)4,6** The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

4. Customary routines and comfort requirements.

6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

Findings:
The plan of care for an identified resident was not current.

Inspector ID #:	170

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 ensuring the plan of care is current, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with **O.Reg. 79/10, s.98** Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:
The home did not notify the police immediately of an occurrence of resident abuse.

Inspector ID #:	170

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 immediate notification of the police, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, 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.	
Findings: March 4, 2011 a staff member did not provide a resident care as per the plan of care.	
Inspector ID #:	170
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 provision of care as per the care plan, to be implemented voluntarily.	

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:** May 24, 2011