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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
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Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 13, 2019	2019_798738_0008	012182-17, 018787-17, 024371-17, 000546-18, 004923-18, 009624-18, 015308-18, 016978-18, 020648-18, 020675-18, 026083-18, 029266-18, 007303-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

AMANDA OWEN (738), KRISTAL PITTER (735)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 23 - 26 and April 29 - May 3, 2019.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #016978-18, CIS #2707-000029-18, Log #020648-18, CIS #2707-000032-18 and Log #007303-19, CIS #2707-000027-19, related to falls prevention;
Log #012182-17, CIS #2707-000027-17 and Log #004923-18, CIS #2707-000012-18, related to infection prevention and control;
Log #015308-18, CIS #2707-000024-18 and Log #020675-18, CIS #2707-000031-18, related to medication;
Log #024371-17, CIS #2707-000039-17, related to alleged staff to resident abuse;
Log #018787-17, CIS #2707-000033-17, Log #000546-18, CIS #2707-000003-18, Log #009624-18, CIS #2707-000018-18, Log #026083-18, CIS #2707-000041-18 and Log #029266-18, CIS #2707-000046-18, related to alleged resident to resident abuse and responsive behaviours.

The following CIS intakes were completed in Complaint inspection #2019_508137_0013:

Log #031313-18, CIS #2707-000053-18, related to falls prevention and Log #003902-19, CIS #2707-000016-19, related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Manager (RCM), Behavioural Support Ontario (BSO) Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Security Guard and residents.

The inspectors also toured the home, observed resident care provision, staff to resident interactions, resident to resident interactions, reviewed residents' clinical records and relevant internal investigation records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #008, #010, #013 and #016 were

protected from abuse by the licensee or staff in the home.

Ontario Regulation 79/10 s. 2 (1) defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Ontario Regulation 79/10 s. 2 (1) defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

A) The home submitted a CIS report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of sexually inappropriate behaviour by resident #007 towards resident #008.

During an interview, PSW #118 said that they had observed resident #007 exhibiting sexually inappropriate behaviours towards resident #008. They said that resident #008 was shaking and they were red in the face at the time of the incident.

A Risk Management report showed that a predisposing factor to the identified incident included a specified behaviour exhibited by resident #008. Resident #007 had no history of sexually inappropriate behaviours prior to this incident.

Resident #008's care plan showed that the resident had a history of a specified behaviour which put them at risk of responsive behaviours from other residents. Interventions to address the identified behaviour were outlined in resident #008's plan of care, however, it was unclear if the interventions were in place at the time of the incident in question. [738]

B) The home submitted a CIS report to the MOHLTC, related to an incident that caused injury to resident #010.

Progress notes showed RPN #121 responded to loud voices and observed residents #009 and #010 standing close to one another. Resident #010 told RPN #121 that resident #009 had hurt them after they had told them to be quiet as other people were sleeping. RPN #121 assessed resident #010 and observed an injury.

A document titled, Head to Toe Skin Assessment2014, showed that resident #010 sustained an injury.

Resident #009's care plan showed that they had a history of specified responsive behaviours directed towards others. Interventions to address the identified responsive behaviours were outlined in the care plan, however, there was no documentation or staff interviews to show that these interventions were in place at the time of the incident.

During an interview, ADOC #105 said they were not aware of residents #009 and #010 having any previous altercations. They acknowledged that resident #010 was harmed because of this incident. [738]

C) The home submitted a CIS report to the MOHLTC, related to an incident that caused injury to resident #013.

During an interview, PSW #123 said that residents #012 and #013 were involved in an altercation. They said that resident #013 sustained an injury as a result of the altercation.

Progress notes showed that resident #013 sustained an injury as a result of an altercation with resident #012.

Progress notes identified that resident #012 had a history of specified behaviours which could be directed at other residents. Interventions were identified in the care plan to address these behaviours.

According to a Responsive Behaviour Huddle assessment, staff had been monitoring resident #012 just prior to the incident in question. However, there was no documentation to show whether other residents were observed to be near resident #012 prior to the incident or if the resident was monitored for agitation.

During an interview, BSO Manager/RPN #122 and PSW #123 acknowledged that resident #013 was injured after an altercation with resident #012. [735]

D) The home submitted a CIS report to the MOHLTC, related to an incident that caused injury to resident #016.

Progress notes showed that a PSW heard screaming and went to investigate. The PSW observed an altercation between resident #015 and #016 which resulted in resident #016 being injured. The progress notes showed that resident #016 was transferred to the hospital following the incident and returned to the home with an injury.

A Risk Management report showed that resident #016 sustained injuries as a result of the altercation with resident #015.

A Responsive Behaviour Huddle assessment showed that resident #015 had a history of identified responsive behaviours, some of which were directed at other residents.

During an interview, BSO Manager/RPN #122 said there were interventions in place to address resident #015's responsive behaviours. However, it was unclear as to whether these interventions were implemented at the time of the incident.

During an interview, RCM #116 said that they were aware of the altercation between resident #015 and #016 in which resident #016 was injured.

The licensee has failed to ensure that residents #008, #010, #013 and #016 were protected from abuse by the licensee or staff in the home. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 12th day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA OWEN (738), KRISTAL PITTER (735)
Inspection No. / No de l'inspection :	2019_798738_0008
Log No. / No de registre :	012182-17, 018787-17, 024371-17, 000546-18, 004923-18, 009624-18, 015308-18, 016978-18, 020648-18, 020675-18, 026083-18, 029266-18, 007303-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 13, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Forest Heights 60 Westheights Drive, KITCHENER, ON, N2N-2A8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Scott Mumberson

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA.

Specifically, the licensee must:
a) Ensure residents #008, #013 and all other residents are protected from abuse from residents #007, #015 and any other residents.
b) Ensure an analysis of every abuse incident is completed that includes but is not limited to:
- strategies in place at the time of the incident to mitigate risk of harm to others
- effectiveness of the strategies

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents #008, #010, #013 and #016 were protected from abuse by the licensee or staff in the home.

Ontario Regulation 79/10 s. 2 (1) defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Ontario Regulation 79/10 s. 2 (1) defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

A) The home submitted a CIS report to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of sexually inappropriate behaviour by resident #007 towards resident #008.

During an interview, PSW #118 said that they had observed resident #007 exhibiting sexually inappropriate behaviours towards resident #008. They said

that resident #008 was shaking and they were red in the face at the time of the incident.

A Risk Management report showed that a predisposing factor to the identified incident included a specified behaviour exhibited by resident #008. Resident #007 had no history of sexually inappropriate behaviours prior to this incident.

Resident #008's care plan showed that the resident had a history of a specified behaviour which put them at risk of responsive behaviours from other residents. Interventions to address the identified behaviour were outlined in resident #008's plan of care, however, it was unclear if the interventions were in place at the time of the incident in question. [738]

B) The home submitted a CIS report to the MOHLTC, related to an incident that caused injury to resident #010.

Progress notes showed RPN #121 responded to loud voices and observed residents #009 and #010 standing close to one another. Resident #010 told RPN #121 that resident #009 had hurt them after they had told them to be quiet as other people were sleeping. RPN #121 assessed resident #010 and observed an injury.

A document titled, Head to Toe Skin Assessment2014, showed that resident #010 sustained an injury.

Resident #009's care plan showed that they had a history of specified responsive behaviours directed towards others. Interventions to address the identified responsive behaviours were outlined in the care plan, however, there was no documentation or staff interviews to show that these interventions were in place at the time of the incident.

During an interview, ADOC #105 said they were not aware of residents #009 and #010 having any previous altercations. They acknowledged that resident #010 was harmed because of this incident. [738]

C) The home submitted a CIS report to the MOHLTC, related to an incident that caused injury to resident #013.

During an interview, PSW #123 said that residents #012 and #013 were involved in an altercation. They said that resident #013 sustained an injury as a result of the altercation.

Progress notes showed that resident #013 sustained an injury as a result of an altercation with resident #012.

Progress notes identified that resident #012 had a history of specified behaviours which could be directed at other residents. Interventions were identified in the care plan to address these behaviours.

According to a Responsive Behaviour Huddle assessment, staff had been monitoring resident #012 just prior to the incident in question. However, there was no documentation to show whether other residents were observed to be near resident #012 prior to the incident or if the resident was monitored for agitation.

During an interview, BSO Manager/RPN #122 and PSW #123 acknowledged that resident #013 was injured after an altercation with resident #012. [735]

D) The home submitted a CIS report to the MOHLTC, related to an incident that caused injury to resident #016.

Progress notes showed that a PSW heard screaming and went to investigate. The PSW observed an altercation between resident #015 and #016 which resulted in resident #016 being injured. The progress notes showed that resident #016 was transferred to the hospital following the incident and returned to the home with an injury.

A Risk Management report showed that resident #016 sustained injuries as a result of the altercation with resident #015.

A Responsive Behaviour Huddle assessment showed that resident #015 had a history of identified responsive behaviours, some of which were directed at other residents.

During an interview, BSO Manager/RPN #122 said there were interventions in place to address resident #015's responsive behaviours. However, it was unclear as to whether these interventions were implemented at the time of the incident.

During an interview, RCM #116 said that they were aware of the altercation between resident #015 and #016 in which resident #016 was injured.

The licensee has failed to ensure that residents #008, #010, #013 and #016 were protected from abuse by the licensee or staff in the home. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual risk/harm to the residents. The scope of the issue was a level 2 as it related to four out of six residents reviewed. The home had a level 3 history of non-compliance with this section of the Act that included:

- Voluntary Plan of Correction (VPC) issued July 2017 (2017_600568_0010)
- Compliance Order (CO) issued September 2017 (2017_600568_0009)

The following Non-Compliance or Actions/Order(s) have been complied with. (738)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 2019

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 13th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Owen

Service Area Office /
Bureau régional de services : Central West Service Area Office