Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2019	2019_755728_0013	010660-19, 010969-19, 011811-19, 011889-19	Follow up

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

MARIA MCGILL (728)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 10, 15-18, 2019.

The following intakes were completed in this follow-up inspection:
Log # 011889-19 related to improper care;
Log # 010969-19 related to related to alleged staff to resident abuse;
Log # 011811-19 related to follow-up of CO#001 from inspection 2019_798738_0008 for s.19 (1) of the LTCHA, 2007, Duty to Protect; and,
Log # 010660-19 related to an improper transfer.

Inspector, Katherine Adamski (753) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Directors of Care (ADOC), Resident Care Managers (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Housekeeping Aides.

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, and the home's documentation related to relevant investigations.

Observations were made of residents, resident to resident interactions, staff to resident interactions, and resident care provision.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_798738_0008	728

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 36, the licensee was required to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. Specifically, staff did not comply with the home's policy titled Wheelchair Safety While Portering.

The Wheelchair Safety While Portering policy last revised on March 31, 2019, directed staff to use footrests at all times unless a resident self-propels.

A critical incident (CI) submitted to the Ministry of Long-term Care (MLTC) documented that resident #001 sustained an injury to an identified area due to an incident that occurred while being portered.

The resident's plan of care at the time the incident occurred documented that resident #001 required specified support for locomotion on the unit.

Progress notes indicated that the resident was complaining of pain to the affected area following the incident. The impacted area was assessed and specified injuries were noted.

ADOC #115, RN #116, and PSW #117 stated that the home's policy for portering residents in wheelchairs directed staff to use footrests at all times when a resident is not able to self-propel.

PSW #117 and DOC #101 said that footrests should have been used in this instance.

The licensee failed to ensure that the home's policy, titled Wheelchair Safety While Portering, was complied with, when resident #001 was portered without the use of footrests. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent care of a resident that resulted in harm or a risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

A CI was submitted to the MLTC on an identified date related to an incident of improper care that occurred one week prior.

DOC #101 said that incidents related to improper and incompetent care are to be reported immediately and that in this instance it was not reported as required.

The licensee failed to ensure that an incident of improper care of resident #001 was reported to the Director immediately. [s. 24. (1)]

Issued on this 26th day of July, 2019

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

Original report signed by the inspector.