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
Oct 24, 2019	2019_508137_0037	017132-19	Complaint

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

MARIAN MACDONALD (137)

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): September 11-13, 16-19 and 24, 2019

A Critical Incident System (CIS) inspection was conducted concurrently during this Complaint inspection, related to alleged abuse/neglect/improper care: 2702-000042-19 under Log #013606-19; 2707-000047-19 under Log #014598-19; 2707-000053-19 under Log #016477-19; 2707-000054-19 under Log #016717-19; 2707-000056-19 under Log #017271-19 (included in the complaint inspection); 2707-000059-19 under Log #018010-19

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8 ,s.19(1) was identified in the CIS inspection and has been issued in Inspection Report 2019_508137_0038, dated October 24, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Resident Care Managers, Staff Development Manager, Physiotherapist, Registered Nurses, Registered Pracrical Nurses, Personal Support Workers, Family and resident.

The Inspector also observed staff to resident interactions, care provision, reviewed resident clinical records, internal investigative notes, family correspondence and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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 an identified resident was protected from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and include inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O.Reg.79/10, s.5

An Infoline Complaint Information report and a Critical Incident System (CIS) report were submitted to the Ministry of Long-Term Care related to alleged abuse and improper care towards an identified resident.

The internal investigation showed an identified staff member had failed to provide care and services to the identified resident on a specified date.

Resident Care Manager (RCM) said the staff member was expected to follow the home's policy and procedures regarding resident care provision but failed to do so on the specified date, which would be considered neglect.

The licensee has failed to ensure that the identified resident was protected from neglect by the licensee or staff in the home. [s. 19. (1)]

Issued on this 28th day of October, 2019

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

Original report signed by the inspector.