Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 19, 2019	2019_795735_0025	020026-19	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

KRISTAL PITTER (735)

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): November 20-21, and 25-29, 2019.

Follow Up Inspection #2019_795735_0026 was conducted in conjunction with this inspection.

The following intakes were completed in this complaint inspection:

Log #020026-19, IL-71215-CW related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Associate Director of Care (ADOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a complainant.

The inspectors also toured resident home areas, observed resident care provision, resident staff interaction, dining services, reviewed relevant residents' clinical records, and relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. This inspection was completed as follow-up to compliance order (CO) #001 from

inspection 2019_508137_0038 issued on October 24, 2019, with a compliance date of November 15, 2019. The following incidents occurred prior to the compliance due date.

The licensee failed to ensure that resident #001 was protected from neglect by the licensee or staff.

Neglect as defined in the regulations is the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern or inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the MLTC which reported an allegation of neglect by staff towards resident #001.

A review of resident #001's progress notes identified multiple signs and symptoms of illness that required staff to provide an identified care for resident #001 numerous times. Complainant #108 and resident #001 communicated to staff that they felt something was going on over a three week period of time, and requested a physician assessment related to the resident's change in condition. A physician order was obtained for laboratory testing for resident #001. Abnormal lab results were documented both in a physician note and by staff after performing a diagnostic test. An order was received from the on-call physician and resident #001 was transferred to hospital for assessment.

A review of resident #001's laboratory investigations identified abnormal results.

A review of the Revera document titled "Quality Improvement Action Plan" indicated that no documentation was found regarding communication of the abnormal results to the physician. The admission Registered Dietitian assessment stated no lab results were available to review and that a specific lab test would be followed up at a later time. Resident #001 had a change in condition with onset of multiple signs and symptoms of illness noted in the progress notes. No follow up was documented and no physician contact was made to suggest specific lab testing. No physician documentation was found in the progress notes until the day before resident #001 was transferred to hospital.

The home's investigation interview notes indicated that registered staff knew the signs and symptoms of illness, but failed to check resident #001's lab results, failed to look for lab results when they couldn't be located, and failed to communicate to oncoming staff that lab results needed to be found. Registered staff acknowledged that a specific illness

should have been considered related to the signs and symptoms exhibited by resident #001.

ADOC #104 stated that no documentation of lab results being communicated to the physician were found. ADOC #104 stated staff did not analyze the lab results nor did they act on the signs and symptoms of illness exhibited by resident #001.

DOC #101 stated that the nurses failed to take action in relation to resident #001's signs and symptoms of illness.

The licensee failed to ensure that resident #001 was protected from neglect by the licensee or staff. [s. 19. (1)]

Issued on this 24th day of December, 2019

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

Original report signed by the inspector.