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
Oct 26, 2021	2021_876606_0021	009088-21, 013655-21	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

JANET GROUX (606)

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): September 22-24, 28-29, 2021.

**The following intakes were completed in this Critical Incident (CI) inspection:
Log #013655-21 regarding the Home's falls prevention program and log #009088-21 related to a resident's change in condition.**

NOTE: A Written Notification related to O. Reg 79/10 r. 8(1)(b) was identified in the complaint inspection #2021_876606_0020 conducted concurrently, and has been issued in this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Staff, Substitute Decision Makers (SDM), and residents.

**During the course of the inspection, the inspectors observed resident and staff interactions and reviewed clinical health records, relevant home policies and procedures, and other
pertinent documents.**

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Medication
Personal Support Services**

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

- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the Home was bathed at a minimum, twice a week.

A concern was raised that residents were not receiving their baths twice a week as scheduled.

A resident said they often did not get a bath due to various reasons and included staff not being available.

The Home's Daily Bath Tracking Tool during specified dates showed a number of scheduled baths for ten residents were not provided.

The Documentation Survey Reports-V2 for those residents showed documentation the residents did not receive a bath as scheduled and no documentation that the missed bath were re-scheduled.

Two nursing staff members said that for a few months in 2021, there had been numerous shifts where residents were not given their bath as scheduled. They said when a resident did not receive their bath on the day the bath was scheduled, their name would be added to the Home's Daily Bath Tracking Tool and given to the Director of Care (DOC). The DOC would schedule a PSW to specifically provide baths to the residents on the list. The nursing staff members and the Assistant Director of Care (ADOC) acknowledged that this did not always happen and residents who missed their baths would not receive another bath until their next scheduled bath day.

Failure to provide residents with regular baths increased their risk for infectious diseases and other health related conditions. [s. 33. (1)]

Sources: the Home's Daily Bath Tracking Tool for identified dates, Documentation Survey Reports-V2 and care plans for identified residents, and interviews with residents and staff.

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 ensure that each resident of the home is bathed, at a minimum, twice a week, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure a resident's medical treatment was documented.

A complaint was submitted to the Ministry of Long Term Care (MLTC) that alleged a staff member refused to provide a resident's specified medical treatment.

A physician's order stated the resident was to receive a specified medical treatment.

The Home's policy required the initiation of a specified medical treatment documented in the Medication Administration Record (MAR/eMAR) or Treatment Administration (TAR/eTAR). The registered staff must signed off the MAR/eMAR or TAR/eTAR each time the resident was administered the specified medical treatment and was monitored for its effectiveness.

The resident's eMARs and eTARs for identified dates in 2021 did not include documentation of the resident's specified medical treatment. Two Registered Practical Nurses (RPN) acknowledged this.

Sources: observations, an identified home's policy and procedure, a resident's clinical records, and interviews with staff. [s. 30. (2)]

Issued on this 3rd day of November, 2021

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

Original report signed by the inspector.