Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: July 24, 2023	
Inspection Number: 2023-1205-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Forest Heights, Kitchener	
Lead Inspector Brittany Nielsen (705769)	**Inspector Digital Signature** Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2023.07.28 11:35:10 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 29-30, July 4-7, 11-13, 2023.

The following intake(s) were inspected:

- Intake: #00087977 related to abuse.
- Intake: #00088194 - complaint regarding neglect, plan of care and administration of drugs.
- Intake: #00090279 related to a fall resulting in transfer to hospital.
- Intake: #00090489 related to injury resulting in transfer to hospital.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain Matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary:
Staff reported an allegation of abuse to management three days after it was brought to their attention.

By failing to report the allegation of abuse immediately, the licensee and Director were unable to respond to the incident in a timely manner.

Sources: critical incident report, the home's internal investigation notes, interviews with staff. [705769]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed to the resident.

Rationale and Summary:
A resident was given a medication they were not prescribed.

By giving the resident the wrong medication, there was risk of the resident having an adverse reaction.

Sources: a resident's clinical records, interviews with a resident and staff. [705769]