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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 15, 2024	
Inspection Number: 2024-1205-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Forest Heights, Kitchener	
Lead Inspector Helene Desabrais (615)	**Inspector Digital Signature** Helene Desabrais Digitally signed by Helene Desabrais Date: 2024.02.16 10:56:44 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 13, 14, 2024

The following intake(s) were inspected:
- Intake: 00103426, related to Infection prevention control;
- Intake: 00105758, related to reports re critical incidents.

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

Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the

licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care to the resident.

Rational and Summary

A resident's specific preferences were not specified in the resident's plan of care. After interviews with the Administrator, the Director of Care, the Assistant Director of Care, the Behavioural Support Ontario-Registered Nurse, a physiotherapist, a Registered Nurse and a Registered Practical Nurse, no clear directions was provided regarding the resident's preferences.

The home's failure to set out clear directions to staff caused them, and the resident, confusion when honoring the resident's preferences.

Sources: A resident's clinical records and interviews with the resident and staff.

[615]

Date Remedy Implemented: February 14, 2024.