Ontario

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: September 23, 2024
Inspection Number: 2024-1205-0002
Inspection Type: Complaint Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Forest Heights, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9 - 13, 2024

The following intake(s) were completed in this complaint inspection:

- Intake: #00121004 – Falls Prevention and Management, Complaints Process and Continence Care.

The following intake(s) were completed in this Critical Incident inspection:

- Intake: #00123226 and Intake: #00121074 – Falls Prevention and Management
- Intake: #00121910 and Intake: #00117393 – Prevention of Abuse and Neglect.

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

Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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Residents' Rights and Choices
Falls Prevention and Management

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 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that plan of care was revised when the care set out in the plan is no longer necessary.

Rational and Summary
One of the fall prevention interventions for a resident was observed on two days to not be in the resident's room.

A PSW stated that the fall prevention intervention was not being used and hadn't been used for a while.

An RN stated that they will remove the fall prevention intervention from the care plan.

The fall prevention intervention was removed from the resident's care plan as it was no longer needed.

Plan of care interventions can be unclear when residents are not reassessed and care plan interventions adjusted.

Sources: Observations, interviews with staff members and resident's clinical records

Date Remedy Implemented: September 12, 2024

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure a resident's substitute decision-maker was given an opportunity to participate fully in the development of the resident's plan of care

regarding their personal care preferences.

Rationale and Summary
The substitute decision-maker for a resident stated that the resident's personal care preference on how their room was to be arranged was not followed.

An RN stated they were aware of the resident's personal care preference, but it was not in their care plan. The RN updated the care plan to include the resident's personal care preference.

The resident is at risk of not having their personal care preference known when this was not documented in the plan of care.

Sources: Observations, resident's clinical record, interviews with staff members and others.