

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

Public Report

Report Issue Date: April 9, 2025

Inspection Number: 2025-1205-0002

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): April 1-4, 7-9, 2025

The following intake(s) were inspected:

- Intake: #00141637 - Allegation of financial abuse of a resident.
- Intake: #00142408 - Concerns regarding a resident's injury of unknown cause.
- Intake: #00142419 - Allegations of abuse and neglect of a resident.
- Intake: #00143323 - Allegation of sexual abuse of a resident.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident received care as specified in their plan of care.

Sources: Observations of the resident, review of the resident's medical records, interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The licensee has failed to protect a resident from abuse by another resident.

Sources: Review of medical record of the resident, interview with the resident and staff.

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WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (2) (e)

Policy to promote zero tolerance

s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

The Licensee failed to ensure the home's zero tolerance of abuse and neglect policy included procedures for how staff respond to an incident of resident to resident sexual abuse.

Sources: the homes Non-Abuse policy, interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately notify the Director of alleged abuse.

Sources: Critical Incident System, interview with staff.

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WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used a device in accordance with manufacturer's instructions.

Sources: Observations of a resident, review of the resident's medical records, interview with staff.

WRITTEN NOTIFICATION: General requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (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.

The licensee has failed to ensure that an intervention was documented on multiple occasions.

Sources: Observations of the resident, review of the resident's medical records,

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interview with staff.

WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that pain management program was implemented for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required that the written policies developed for Pain Management Program was complied with.

Sources: Observations of a resident, review of the resident's medical records, review of the home's policy - Pain Assessment and Management, interview with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

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(b) identifying and implementing interventions.

The licensee failed to minimize the risk of potentially harmful interactions between and among residents when they failed to ensure an intervention was in place for a resident on multiple occasions.

Sources: observations, review of Responsive Behaviour procedures, interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a Registered Practical Nurse administered medication for a resident, as specified by the prescriber.

Sources: Observations of the resident, review of the resident's medical records, interview with staff.