Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2014	2014_258519_0015	L-000356-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

SHERRI GROULX (519)

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): June 17, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, two Assistant Directors of Nursing, and two Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the Resident's clinical record and assessments, the home's Internal investigation notes, the home's policy on Abuse and Neglect, and other relevant documents. Observed the general environment and care delivered in the home.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A Resident was not treated with courtesy and respect and his/her dignity was not respected when he/she was left having to wait for the completion of care, lying on an uncomfortable surface, while the PSW went to attend to other duties.

Upon interview it was shared that the PSW did not return to the resident in a timely manner.

This PSW was then sent home immediately pending an investigation for the allegation of neglect of the resident.

This was confirmed by the home's investigation notes written by the Interim Director of Nursing, the Assistant Director of Nursing and the previous Director of Nursing.[s. 3. (1) 1.]

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 to ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A Resident was left waiting for care to be completed, lying on an uncomfortable surface, when the Personal Support Worker caring for this resident left to attend to other duties. The resident did not suffer any injury as a result of this action. The Personal Support Worker was sent home pending an abuse/neglect investigation.

A note on the clinical record indicated that a voice mail was left by the Assistant Director of Nursing at an unknown time, stating the resident was fine and they were calling to leave an update. There was no mention in the voice mail of the alleged incident of neglect and the SDM did not return the phone call.

The notification of the SDM by voicemail was left later than the 12 hours required under the Ontario Regulation 79/10, r.97(1)(b). The message left did not provide the information about the alleged abuse/neglect to the SDM. [s. 97. (1) (b)]

2. The licensee failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Upon interview with the Assistant Director of Nursing it was confirmed that the incident of alleged abuse/neglect that occurred with was not directly communicated to the SDM through the voice mail that was left. As the SDM did not return the voice mail message, the Assistant Director of Nursing confirmed it was not known if the results of the investigation upon completion had been communicated as well. [s. 97. (2)]

3. Upon interview with the Administrator it was confirmed that the results of the alleged abuse/neglect investigation were not reported to the Resident's SDM on completion. [s. 97. (2)]

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 to ensure that the resident's SDM and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home's Policy on Abuse and Neglect states under Mandatory Reporting (Internal), that the incident must be reported by staff following the Adverse Event Algorithm.

Upon interview with one Assistant Director of Nursing (ADON) it was confirmed that the home's expectation would be that an Internal "incident" report would be filled out following an incident of alleged abuse/neglect. The ADON was unaware if an Internal report had been completed.

Upon interview with the second Assistant Director of Nursing(ADON)it was confirmed that the Internal report on the alleged abuse/neglect could not be located.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with. [s. 20. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Upon interview with the Administrator of the home it was confirmed that the results of the abuse/neglect investigation on the incident that occurred in the home were not reported to the Director. [s. 23. (2)]

Issued on this 20th day of June, 2014

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