



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

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

Health System Accountability and
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Performance Improvement and
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Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité

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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
Jan 23, 2013	2013_128138_0001	O-000616- 12	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

HEARTWOOD
201-11TH STREET EAST, CORNWALL, ON, K6H-2Y6

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 9 and 14, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Education Coordinator, and personal care workers.

During the course of the inspection, the inspector(s) reviewed a resident health record, reviewed Critical Incident Report, reviewed internal incident documents, reviewed employee records, and observed a resident.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :



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1. The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 6. (7) in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan of care.

A Critical Incident Report was submitted to MOHLTC stating that a resident fell on a day in March 2012, suffered injury, and was transported to hospital after staff failed to apply the resident's personal assistance service devices.

A review of the resident's care plan confirmed that the resident was care planned to minimize falls and that s/he was to be in a tilt chair with a lap tray at all times. The Director of Care confirmed that this care plan was in place at the time of the resident's fall in March 2012.

Further review of the progress notes in the resident's health record and internal incident documents indicated that the resident was left in her/his chair by staff without the chair being put in a tilt position and without application of the lap tray.

A staff member involved in the incident confirmed that s/he left the resident in room without tilting the tilt chair and applying the lap tray. Two staff members both received disciplinary action for their actions relating to resident's fall. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.



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Issued on this 23rd day of January, 2013

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

Paula MacDonnell RD