



**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
Direction de l'amélioration de la
performance et de la conformité**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 4, 2015	2015_181105_0012	003323-15, 004883-15, 007517-15	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

JUNE OSBORN (105), DEBORA SAVILLE (192)

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): June 26, 27, 2015

This inspection included the following critical incident reports:

**Log# 003323-15, Log# 004883-15, Log# 007517-15, Log#003704-15, Log# 004793-15,
Log# 009000-15.**

During the course of the inspection, the inspector(s) spoke with 5 Residents, 1 Registered Practical Nurse, 1 Personal Support Worker, and the Director of Care. In addition the following were reviewed: policies and procedures, incident investigation notes, medical records, and staff education records.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 24. Reporting certain matters to Director



Specifically failed to comply with the following:

s. 24. (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:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 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. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident, that resulted in risk of harm, had occurred, immediately report the suspicion and the information upon which it was based to the Director.

Resident #002 was observed by a Personal Support Worker to have been sexually abused by resident #001 on a specified date.

The observed incident of abuse was not reported to the Director until greater than twenty-four hours later, when the Critical Incident System report was initiated.

Interview with the Director of Care confirmed that the manager on call would have been notified by staff of the home, of the incident occurring on the specified date involving resident #001 and #002.

Interview with the Director of Care confirmed that the Director was not notified when the manager responsible for the home on the specified date using the after hours contact number or the Critical Incident System.

The licensee failed to notify the Director immediately upon becoming aware of sexual abuse of a resident that resulted in a risk of harm. [s. 24. (1)]



WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

- i. names of all residents involved in the incident,**
- ii. names of any staff members or other persons who were present at or discovered the incident, and**
- iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:

(ii) names of any staff members or other persons who were present at or discovered the incident.

Review of the home's investigation notes revealed the names of the persons allegedly responsible for the neglect of care of Resident #006 on 2 separate occasions.

Review of the 2 Critical Incident Reports related to the investigation notes revealed that the persons allegedly responsible for the neglect of care were not mentioned in the reports.

The Director of Care verified that the persons' names did not appear in the critical incident reports, and acknowledged that they should be included. [s. 104. (1) 2.]



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Issued on this 4th day of June, 2015

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

Original report signed by the inspector.