Ontario

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2019	2019_508137_0038	013606-19, 014598-19, 016477-19, 016717-19, 017271-19, 018010-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

MARIAN MACDONALD (137)

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): September 11-13, 16-19 and 24, 2019

The following Critical Incidents System (CIS) reports were inspected related to alleged abuse/neglect/improper care:

2702-000042-19 under Log #013606-19
2707-000047-19 under Log #014598-19
2707-000053-19 under Log #016477-19
2707-000054-19 under Log #016717-19
2707-000056-19 under Log #017271-19 (included in a concurrent complaint inspection)
2707-000059-19 under Log #018010-19

A Complaint Inspection, 2019_508137_0037, under Log #017132-19 was conducted concurrently during the CIS inspection and included 2707-000056-19 under Log #017271-19.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Resident Care Managers, Staff Development Manager, Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeper, Family and residents.

The Inspectors also toured resident home areas, observed staff to resident and resident to resident interactions, care provision, reviewed resident clinical records, internal investigative records and relevant policies and procedures.

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

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

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and include residents. O.Reg.79/10, s.5

1. The licensee has failed to ensure that several identified residents were protected from neglect by the licensee or staff in the home.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) stating care was not provided to several identified residents on a specified date.

The Resident Care Manager (RCM) said, as part of a specified shift routine, PSWs were expected to complete rounds with a partner. The home had a "White Dot" program where white dots were placed on hallway resident name plates which indicated those residents had the potential for responsive behaviours. The white dot cued staff that a two-person approach was required during any interaction or care task with the resident. The identified residents wore continence care products designed for night time use. The identified staff member documented that they changed the residents but only two soiled continence care products were observed in the garbage at the end of the shift. Several of the residents had wet beds and two were found wearing double continence care products, which did not support the home's continence management policy.

An internal investigation showed an identified staff member did not ask the nurse or other staff for help as no residents were aggressive, did not follow the "white dot" home specific procedure, did not provide care rounds with a partner, did not follow the continence management policy related to applying double continence care products, did not reference the residents' Kardex and care plan and did not provide care as per the plan of care for the identified residents.

Resident Care Managers (RCM) said the identified staff member was expected to follow the home's policy and procedures regarding resident care provision but failed to do so, which would be considered neglect.

The licensee has failed to ensure that several identified residents were protected from neglect by the licensee or staff in the home.

2. The licensee has failed to ensure that an identified resident was protected from neglect by the licensee or staff in the home.

A CIS report was submitted to the MLTC stating an identified staff member "forgot" to provide care to an identified resident on a specified date.

A review of the home's internal investigation records showed that the staff member received report that the health status of the identified resident had deteriorated but forgot to provide personal care, such as continence care, oral care and repositioning, on a specified date.

The Resident Care Manager (RCM) said the identified staff member was expected to follow the home's policy and procedures regarding resident care provision but failed to do so, which would be considered neglect.

The licensee has failed to ensure that the identified resident was protected from neglect by the licensee or staff in the home.

3. The licensee has failed to ensure that an identified resident was protected from neglect by the licensee or staff in the home.

A CIS report was submitted to MLTC stating an identified resident sustained a fall without injury but indicated they hit their head. The incident was reported to the registered staff member,

A review of the home's internal investigative records showed that the registered staff member did not document the incident in Point Click Care (PCC) or in Risk Management, did not initiate a Head Injury Routine, did not document in the 24-hour report and did not report the fall to the oncoming shift, as per the home's policy and procedure.

During an interview, the RCM said the registered staff member was expected to follow the home's policy and procedure related to falls prevention but failed to do, which would be considered neglect.

The licensee has failed to ensure that the identified resident was protected from neglect by the licensee or staff in the home. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 28th day of October, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIAN MACDONALD (137)
Inspection No. / No de l'inspection :	2019_508137_0038
Log No. / No de registre :	013606-19, 014598-19, 016477-19, 016717-19, 017271-19, 018010-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 24, 2019
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Forest Heights 60 Westheights Drive, KITCHENER, ON, N2N-2A8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Scott Mumberson

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA.
Specifically, the licensee must:

a) Ensure that all residents are protected from neglect by the licensee and staff.
b) Ensure night rounds and safety checks of residents are being completed as per the home's policy and procedure.
c) Ensure registered staff complete post-fall documentation, including assessments, Head Injury Routine, pain monitoring guidelines, Risk Management report, post-fall huddle and reporting to the oncoming shift, as per the home's policy and procedure.
d) Develop, implement and document an auditing system that is completed at regular intervals to ensure night rounds and safety checks, care provision and post-fall documentation are completed in accordance with the home's policies and procedures.

Grounds / Motifs :

1. For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and include residents. O.Reg.79/10, s.5

1. The licensee has failed to ensure that several identified residents were protected from neglect by the licensee or staff in the home.

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The licensee has failed to ensure that the identified resident was protected from neglect by the licensee or staff in the home. [s. 19. (1)]

The scope of this area of non-compliance was level 3, widespread. The severity was level 2, minimal harm or minimal risk. The home has a level 4 compliance history, with a Compliance Order being re-issued related to the same subsection of the Legislation and three or fewer Compliance Orders within the last 36 months.

It was issued as a:
Written Notification and Compliance Order on May 13, 2019, under Inspection # 2019_798738_0008, during a Critical Incident System (CIS) Inspection;

Written Notification and Voluntary Plan of Correction (VPC) on July 13, 2017, under Inspection #2017_600568_0010, during a Critical Incident System (CIS) Inspection;
Written Notification and Compliance Order on September 13, 2017, under Inspection #
2017_600658_0009, during a Resident Quality Inspection (RQI).
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

Service Area Office /
Bureau régional de services : Central West Service Area Office