Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: December 19, 2024
Inspection Number: 2024-1205-0003
Inspection Type: Critical Incident (CI)
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): December 12-13, 17-19, 2024

The following intake(s) were inspected:

- Intake: #00127082 - Responsive Behaviours
- Intake: #00131458 and #00133167- Falls Prevention and Management

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their strategies to reduce or mitigate falls for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there were strategies to reduce or mitigate falls and that they were complied with for a resident.

The home's Fall Prevention and Injury Reduction Program showed that in the case of a resident fall, strategies were to be put in place to prevent a further fall and reduce the risk of a fall-related injury.

A resident required a fall prevention intervention and the home did not ensure that this intervention was in place resulting in the resident falling.

When the resident sustained a fall, it put their existing injury at risk of impaired healing and further injury.

Sources: progress notes, post fall assessments, care plan, Fall Prevention and Injury Reduction Program (March 31, 2024), interview with a RPN and other staff.

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that procedures and interventions were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident #001's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The home's Behavioural Support Ontario (BSO) policy and procedures directed staff to implement specific interventions for resident's exhibiting physical responsive behaviours and resident #001's plan of care included specific interventions during times of increased behaviours.

Staff had identified that resident #001's behaviors were increasing, specific interventions were not implemented.

Resident #001 had a physical altercation with resident #005 resulting in harm to resident.

Interventions were not implemented, not evaluated for effectiveness or incomplete.

Later in the day, resident #001 had a physical altercation with resident #002 resulting in harm to the resident.

When interventions were not implemented, not evaluated for effectiveness or incomplete, resident #001 had two incidents with resident's #002 and #005.

Sources: progress notes, care plans, eMAR, DOS Documentation, BSO Policy and Procedure (reviewed March 31, 2024), and Algorithm, interview with the BSO Lead and other staff.