



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

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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
May 6, 2013	2013_171155_0015	L-000187-13	Complaint

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

SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 23 and 24, 2013.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Admission Manager, Resident Services Coordinator, Registered Nurse, 3 Registered Practical Nurses, Ward Clerk, Personal Support Worker, 2 Residents, and 2 Family members.

During the course of the inspection, the inspector(s) toured a resident living area; reviewed policy and procedure related to this inspection; observed staff and resident interactions; observed care provided to residents and reviewed resident clinical records.

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

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



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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

- s. 6. (9) The licensee shall ensure that the following are documented:**
- 1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
 - 2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
 - 3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

Findings/Faits saillants :



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1. A restraint was removed from a resident without the resident's substitute decision maker being given the opportunity to participate fully in the development and implementation of the resident's plan of care. The resident sustained an injury as a result of the restraint not being in place. This was confirmed by Registered Staff and family. [s. 6. (5)]
 2. Six out of twelve (50%) residents reviewed had no care plans available for convenient and immediate access by the staff and others who provide direct care to the residents. This was confirmed by Registered staff. [s. 6. (8)]
 3. Review of a resident's Continuous Care Flow Sheet shows that HS cares (partial bed bath as per care plan includes mouthcare, pericare, skin care) is not documented for evenings on 14 of the 23 days (61% of the time). This was confirmed by Registered staff. [s. 6. (9) 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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; and to ensure that the provision of the care set out in the plan of care is documented., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices



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Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. A resident was observed with a restraint on. There was no consent for the restraint. This was confirmed by the Registered Staff. [s. 31. (2) 5.]

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 the restraining of a resident by a physical device may be included in a resident's plan of care only if the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110.
Requirements relating to restraining by a physical device**



Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without



limiting the generality of this requirement, the licensee shall ensure that the following are documented:

8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. A restraint was removed from a resident. The restraint was not applied in accordance with the instructions specified by the physician. This was confirmed by a Registered Practical Nurse. [s. 110. (2) 2.]
2. A resident was observed sitting in a wheelchair with a restraint in place. There was no consent for the restraint. [s. 110. (7) 4.]
3. A resident was wearing a restraint. There was no documentation as to who applied the seat belt restraint nor the time of the application. The Registered Staff was not aware that the resident had a restraint on. Personal Support Workers confirmed that the seat belt restraint was on. [s. 110. (7) 5.]
4. A resident was wearing a restraint. At the time of the inspection, review of the resident's Restraint Observation Form revealed that there was no documentation regarding who applied the device and the time of application; assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care since April 22, 2013 at 0630 hours. This was confirmed by the Registered Nurse. [s. 110. (7) 5.]



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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 staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class; to ensure the following are documented: consent, the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

- s. 27. (1) Every licensee of a long-term care home shall ensure that,**
- (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**
 - (b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**
 - (c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**

Findings/Faits saillants :

1. A resident's 6 week admission care conference was not scheduled to take place until after 6 weeks post admission. This was confirmed by the Resident Services Coordinator. [s. 27. (1) (a)]



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Issued on this 6th day of May, 2013

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

SHARON PERRY