Ontario

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
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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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 3, 2014	2013_303563_0011	L-001018-13	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

MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 16, 17, and 18

During the course of the inspection, the inspector(s) spoke with the interim Administrator, Director of Care, Assistant Director of Care, Program Manager, Registered Practical Nurse, and three Residents.

During the course of the inspection, the inspector(s) made observations of resident's room, medication room and refrigerator. Reviewed health records, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

Voluntary Plans of Correction were previously issued on the following dates within the past three months:

a) October 25, 2013
b) November 20, 2013
c) December 3, 2013
d) December 4, 2013
e) December 18, 2013

The licensee of the long term care home failed to ensure that staff are to comply with specific policies of the home.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity as evidenced by:

a) Resident explained that staff have entered his/her room to remove items without consent and in the resident's absence. Management confirmed staff have entered the Resident's room and removed items in his/her absence and this should not happen.

b) Resident explained that staff enter the Resident's room without knocking and management confirmed this is happening regularly despite reminders not to.

2. The licensee failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be properly fed and cared for in a manner consistent with his/her needs. Resident stated the home is offering an apple at snack without an alternative. Management confirmed the fruit bowl would be offered if the resident did not want the snack option available and the Resident confirmed an alternative was not provided. The home failed to provide him/her with the appropriate snack options in a manner that is consistent with his/her needs. [s. 3. (1) 4.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: safety risks and mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day as evidenced by:

a) Management confirmed the resident demonstrates responsive behaviours and that none of the behaviours were care planned and staff would expect to see those instructions for residents with behaviours in the care plan.

b) Management confirmed that the Behavioural Supports Ontario (BSO) nurse had the expectation to assess the resident and put in place a responsive behaviours care plan that provides clear and specific direction to staff caring for him/her and management confirmed this did not occur.

c) Management confirmed that a care plan addressing the resident behaviours should have been established by the nursing staff prior to a BSO assessment and intervention.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee failed to ensure that a manual wheelchair is available at all times to residents who require them on a short-term basis as evidenced by:

a) Management confirmed they did not ensure a manual wheelchair was made available to the resident on a short term basis.

b) Management confirmed they told the resident to pay $75 for the rental of a manual wheelchair on a short term basis.[s. 39.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not respond to the Residents' Council in writing within 10 days of receiving the advice as evidenced by:

a) Management could not provide evidence that written response was provided to the Residents' Council within 10 days.

b) The President of Residents' Council explained complaints regarding specific issues where raised on numerous occasions without a satisfactory response from management. [s. 57. (2)]

Issued on this 24th day of January, 2014

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

Melanie Northey