

**Ministry of Health
and Long-Term Care**

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
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**Ministère de la Santé
et des Soins de longue durée**

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4^{ième} étage
Ottawa ON K1S 3J4
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January 24, 2012

Ms. Karen Roth
Administrator
Heatwood
201-11th Street East
Cornwall ON K6H 2Y6

Dear Ms. Roth:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on January 4, 5, 6, 10 and 11, 2012 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely


Paula MacDonald
LTC Home Inspector – Dietary

c President, Resident's Council
President, Family Council



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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 4, 5, 6, 10, 11, 2012	2012_128138_0001	Critical Incident

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

HEARTWOOD
201-11TH STREET EAST, CORNWALL, ON, K6H-2Y6

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Education Coordinator, Personal Support Workers, a Housekeeping Aide, Residents, and Registered Nursing Staff.

During the course of the inspection, the inspector(s) conducted two Critical Incident inspections, interviewed staff and residents, reviewed health care records for residents, reviewed the home's training programs, and reviewed policy and procedures relating to prevention of abuse. The inspection occurred on-site January 4 and 5, 2012.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
 - i. participate fully in the development, implementation, review and revision of his or her plan of care,
 - ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 - iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
 - iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
 - i. the Residents' Council,
 - ii. the Family Council,
 - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
 - iv. staff members,
 - v. government officials,
 - vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c. 8, s. 3. (1) 1. relating to the conduct of a staff member that was not respectful nor dignified towards two residents as well as the conduct of another staff member that was not respectful nor dignified towards a resident.

2. On a shift in December 2011, a staff member was frustrated and used a raised voice in an attempt to manage behaviours from a resident. This incident was witnessed by another staff member.

3. On a shift in December 2011 a resident rang for assistance to be put into bed. His/her request was not respected and instead s/he was taken by a staff member to the TV lounge via wheelchair where s/he did not request to go. The resident left the TV lounge and self propelled his/her wheelchair back to his/her room. At this time, a staff member was observed by another staff member to roughly handle the resident and return him/her to the TV lounge where s/he did not want to be. The resident once again exited the TV lounge to attempt to return to his/her room.

4. The resident confirmed s/he recalled the events. S/He stated that his/her desire was to go to bed but was not assisted. S/He further stated that s/he recalled that a staff member grabbed his/her arm and took the resident somewhere s/he did not want to go.

WN #2: 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 subsections:

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.

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.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

4. Misuse or misappropriation of a resident's money.

5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. A personal Support Worker reported that s/he witnessed an incident of suspected staff to resident abuse on a shift in December 2011 but did not report it until the following day.



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Issued on this 11th day of January, 2012

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

Paula MacDonald