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

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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
Oct 7, 2014	2014_340566_0015	T-178-14	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

HUMBER VALLEY TERRACE
95 Humber College Blvd., Rexdale, ON, M9V-5B5

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

ARIEL JONES (566)

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): September 15, 16, 17, and 19, 2014.

This inspection was performed in conjunction with the Resident Quality Inspection (RQI), T-042-14 (#2014_340566_0014).

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), environmental services manager (ESM), dietary manager (DM), food service manager (FSM), programs manager, registered staff members, personal support workers (PSW), dietary aides, laundry aide, residents, and the complainant.

During the course of the inspection, the inspector(s) observed staff to resident interactions and provision of care, observed meal service, medication administration, reviewed relevant home records, relevant policy and procedures, and resident health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Food Quality
Responsive Behaviours

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 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every residents' right to live in a safe environment, is fully respected and promoted.

A review of the home's complaints and interviews with resident #021 and the complainant revealed that the resident was struck in an identified area of the lower extremity by an identified assistive device that resident #024 had been pushing in an identified area of the home on a specified date, and that the resident was so upset by the incident that he/she called the police. Record review revealed that resident #021 sustained an identified injury to an identified area of the lower extremity following the incident.

Interviews with both registered and non-registered staff confirmed that resident #024 demonstrates behaviours around pushing the identified assistive device of co-residents in the home, that he/she once hit resident #021 in the lower extremity unintentionally while performing the identified behaviour, and that he/she is not allowed to perform the identified behaviour unless supervised by the programs staff during a designated activity.

Interviews with the ADOC, DOC, and ED indicated that the home viewed the incident as accidental contact, and not as resident-to-resident abuse since resident #024 did not intentionally hit resident #021 with the identified assistive device, and a report to the MOHLTC or the police was therefore not required. The police reportedly responded to resident #021's call, but simply spoke to both residents and encouraged resident #024 not to do it again.

An interview with the ED confirmed that resident #021's right to live in a safe environment was not respected and promoted. [s. 3. (1) 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 that every residents' right to live in a safe environment is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Record review of resident #024's written plan of care indicated that the resident exhibits an identified responsive behaviour, and requires redirection and encouragement not to perform the identified behaviour when the behaviour is observed.

On two specified dates, the resident was observed by the inspector to be performing the identified behaviour in an identified home area without the intervention of nearby nursing or dietary staff. On a third date, the resident was observed by inspector #589 moving quickly while performing the identified behaviour between two identified home areas without supervision.

Interviews with both registered and non-registered staff confirmed that resident #024 does exhibit the identified behaviour in the home environment, and that if observed, staff are to redirect the resident and encourage him/her to stop due to safety concerns.

An interview with the ED confirmed that if staff allow resident #024 to perform the identified behaviour without discouraging or redirecting the resident, the intervention has not been provided as set out in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective,

different approaches are considered in the revision of the plan of care.

A review of the written plan of care for resident #024 indicated that since a specific date, the resident has exhibited an identified responsive behaviour. Specific interventions were outlined within the care plan to manage the resident's responsive behaviours. There is no evidence that the resident's written care plan interventions related to responsive behaviours were revised after being initiated on the specified date.

Interviews with registered and non-registered staff revealed that the resident is not allowed to perform the identified behaviour in the home, and that he/she is to be redirected and encouraged to stop, if observed; however, that this intervention is only temporarily effective. An interview with an identified member of the registered staff revealed that the resident requires frequent reminders not to perform the identified behaviour, that he/she may get agitated if redirected, and that other interventions have not been tried.

Resident interview revealed, and record review and staff interviews confirmed, that while resident #024 performed the identified behaviour on a specified date, incidental contact was made with an identified area of resident #021's lower extremity, resulting in injury.

On three specified dates, the resident was observed by the inspector and inspector #589 performing the identified behaviour in identified areas of the home without staff intervention.

Interviews with the ADOC and DOC confirmed that staff are to discourage resident #024 from performing the identified behaviour; however, that this strategy is only effective in the moment, that the resident requires constant supervision, and that both staff and visitors continue to report to management that they have seen resident #024 performing the identified behaviour within the home environment.

Different approaches to prevent this behaviour have not been considered in the reassessment or revision of resident #024's plan of care since it was initiated on the identified date. [s. 6. (11) (b)]

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 plan of care provides the following:
1. that the care set out in the plan of care is provided to the resident as specified in the plan, and
2. that if the plan of care is being revised because the care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 31st day of October, 2014

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