Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 23, 24, 29, 31, 2011	2011_078193_0018	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

MONICA NOURI (193)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with family members, direct care staff, registered staff, Physiotherapist (PT) and Director of care.

During the course of the inspection, the inspector(s) reviewed health records, home's Falls management program and Resident non abuse policy.

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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

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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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits sayants :

1. The plan of care for an identified resident noted that the resident is to be transferred using a mechanical lift with 2 person physical assist. The resident was transferred using the mechanical lift with one person assist and sustained an injury that required hospitalization.[6(7)]
2. SALT(Safe ambulation, lift and transfers) team members did not collaborate with PT when assessing an identified resident for mode of transfer, as per records, registered staff and PT statements. SALT team decided to use 2 staff manual transfer with a transfer belt, while PT recommended as safe mode of transfer the use of mechanical lift with 2 person assistance.[6(4)(a)(b)]
3. a) PT assessment noted that an identified resident is to be transferred by mechanical lift with 2 person physical assist. The Resident care plan and the Transfer/lift assessment completed by the SALT team noted that the resident is a 2 person side by side manual transfer with a transfer belt.[6(1)(c)]
b)MDS (Minimum Data Set) assessment does not identify the resident as having unsteady gait , while PT assessment identifies the resident with unsteady gait.[6(1)(c)(4)(a)]

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 by ensuring that the plan of care for [redacted] resident of the home provide clear direction to staff and others who provide direct care to the residents, the care set out in the plan of care is provided to the residents as specified in the plan, and the staff and others involved in the different aspects of care collaborate with each other in the assessment of the residents, development and implementation of the plan of care so that their assessme, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits sayants :

The home did not protect an identified resident from neglect. The resident was neglected by the assigned direct care staff who failed to transfer the resident using the mechanical lift with another staff assistance, transferring the resident alone. As a result, the resident sustained an injury that required hospitalization.[s.19(1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits sayants :

1. An identified staff member, did not use safe transferring techniques when assisting an identified resident. The resident sustained an injury and required hospitalization.[r.36]
2. An identified resident is being transferred manually with 2 persons physical assist when PT recommendation for a safe transferring technique was for a mechanical transfer with 2 persons physical assist.[r.36]

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 by ensuring that residents of the home are transferred by staff using safe transferring techniques, to be implemented voluntarily.

Issued on this 31st day of August, 2011

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

M. Nour