Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8ièm étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
1-866-311-8002

Télécopieur: 416-327-4486

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of inspection/Genre d'inspection
November 30 and December 2, 2010	2010_189_2716_30Nov104547 T-1707	Critical Incident

Licensee/Titulaire
Revera Long Term Care Inc.
55 Standish Court, 8th floor
Mississauga, Ontario
L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Humber Valley Terrace
95 Humber College Blvd
Etobicoke, Ontario
M9V 5B5

Name of Inspector(s)/Nom de l'inspecteur(s)
Nicole Ranger (189)

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Administrator, Director of Nursing, Registered staff, Personal Support Workers.

During the course of the inspection, the inspector:

Conducted a walk through of resident home area and common areas
Review health care records
Reviewed the home's Falls Prevention Program

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

Hospitalization and Death Inspection Protocol
Falls Prevention Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA, 2007, S.O.2007, c.8, s.19(1)**

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:

1. A resident did not receive immediate assistance following an incident

Inspector ID #:	189

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 staff provide immediate assistance to residents who require actions to prevent jeopardy to the health, safety or well-being of one or more residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O.2007, c.8, s.3 (1) 3**

3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

3. Every resident has the right not to be neglected by the licensee or staff

Findings:

1. A resident did not receive immediate assistance following an incident

Inspector ID #:	189

WN #3: The Licensee has failed to comply with **LTCHA, 2007, S.O.2007, c.8, s.6 (7)** **(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: 1. A resident was not provided with care as set out in the plan of care .

Inspector ID #:	189

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	Date of Report: (if different from date(s) of inspection). December 20th, 2010