



**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**

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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
Sep 11, 2013	2013_163189_0020	T-209-13	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

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

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

NICOLE RANGER (189)

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): August 23 and August 28, 2013

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Registered Staff, Personal Support Worker, Resident Care Coordinator, Environmental Service Manager

During the course of the inspection, the inspector(s) Reviewed health care records

**The following Inspection Protocols were used during this inspection:
Personal Support Services**



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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. 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).

Findings/Faits saillants :



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

Resident #1 admission orders required urine sample for urinalysis taken upon admission to the home. Record review of initial laboratory record reports urinalysis collection delayed. Inspector spoke with laboratory representative who reported that there was no urine sample received with the initial laboratory sample. This result was not followed by the staff and the urine sample was not provided until one month later. This was confirmed by the Director of Care.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,

(i) residents' linens are changed at least once a week and more often as needed,

(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,

(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and

(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :



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1. The licensee failed to ensure that residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing.

Resident #1 was admitted to the home on an identified dated. Staff interviews and record review revealed that residents' clothing was sent down to laundry on admission for labelling. The resident did not receive his/her clothing returned until three days after. This was confirmed by the Director of Care.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131.

Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #1 complained of a sore throat. Resident was assessed by the Nurse Practitioner (NP) on the same day and the NP ordered Lozenges when needed (prn) for sore throat. Record review and staff interviews revealed that the NP orders were faxed to the main pharmacy during the day. In the evening, the pharmacy sent a note back to the home that the medication was not available. Staff interview revealed that as per home's policy, if the medication is not available from the main pharmacy, registered staff are to fax orders to the satellite pharmacy. Inspector reviewed records and confirmed with staff that orders for lozenges were not faxed to the satellite pharmacy. Resident did not receive lozenges for four days and did not receive her medication as prescribed. [s. 131. (2)]



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Issued on this 23rd day of September, 2013

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

A handwritten signature in black ink, appearing to read "Nicole Karp", written over a white background within a rectangular box.