

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) /	Inspection No /	Log # <i>/</i>	Type of Inspection /
Date(s) du apport	No de l'inspection	Registre no	Genre d'inspection
May 26, 2015	2015_190159_0012	H-002152-15	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

BAYWOODS PLACE 330 MAIN STREET EAST HAMILTON ON L8N 3T9

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): May 22, 25, 2015

During the course of the inspection, the inspector interviewed staff, residents, reviewed clinical records, relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service/Nutrition Manager,Registered staff, Personal Support Workers (PSWs) and dietary staff.

The following Inspection Protocols were used during this inspection: Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.

1 WN(s) 0 VPC(s) 0 CO(s) 0 DR(s) 0 WAO(s)



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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES			
Legend	Legendé		
<ul> <li>WN – Written Notification</li> <li>VPC – Voluntary Plan of Correction</li> <li>DR – Director Referral</li> <li>CO – Compliance Order</li> <li>WAO – Work and Activity Order</li> </ul>	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.		



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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:

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. 2007, c. 8, s. 3 (1).

## Findings/Faits saillants :

1. The licensee failed to ensure resident #001 fully participated in decision of their transfer to a secure unit within the home and obtained the consent and approval of resident or resident's Power of Attorney(POA). February 2015, staff in the home transferred resident #001 to secure unit within the home without resident's full participation in decision of their transfer to secure unit and did not obtain approval and consent of resident or resident's POA prior to move. The Administrator and the Director of Care stated the POA was notified prior to such a move occurring but did not consent to the move. The resident's records did not indicate any other actions were attempted to maintain resident's safety at the POA denied consent. The resident did not fully participate in transferring to secure unit and the home did not receive approval and the consent of resident or resident's POA. [s. 3. (1) 11. iii.]



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Issued on this 27th day of May, 2015

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

Original report signed by the inspector.