Ontario

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
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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
Dec 12, 2013	2013_248214_0004	H-000670-13,H-000094-13	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

Long-Term Care Home/Foyer de soins de longue durée

POST INN VILLAGE
203 Georgian Drive, OAKVILLE, ON, L6H-7H9

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

CATHY FEDIASH (214) and Gillian Tracey (130) dm

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): December 3, 4, 5 and 10, 2013

Please Note: This inspection was conducted simultaneously with inspection #H-000615-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care, personal support workers, registered staff, laundry staff, family members and residents.

During the course of the inspection, the inspector(s) interviewed staff, residents and families, reviewed clinical records, applicable policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Continence Care and Bowel Management

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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

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. 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 did not ensure that every resident was given the right to give or refuse consent to any treatment, care or services for which his or her consent was required by law.

a) In 2013, the physician ordered a specific test to be conducted for resident #006. According to the clinical record, the test was performed. Staff confirmed that consent was not obtained prior to the test being done. [s. 3. (1) 11. ii.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system in place was complied with. The home's policy and procedure, "Lost and Found", [15-02-02-11] indicated: 1. "If an article is reported lost or missing, unit staff will first do a thorough search of the immediate area and neighboring closets", and 2. "If the article is not found, a Missing Article Resident Report form will be completed and forwarded to the Environmental Supervisor".

a) In 2013, a "Missing Items Record" was initiated for missing articles of clothing belonging to resident #006, however, the form was incomplete and did not identify whether or not the resident/family were satisfied. A second "Missing Items Record" was initiated at a second date in 2013 and did not identify whether or not the missing items were found. Staff interviewed confirmed the forms were incomplete.

b) According to the clinical record, the family of resident #006 reported a missing article of clothing on a third date in 2013. Staff interviewed confirmed that a "Missing Article Resident Report" was not initiated for this missing item. [s. 8. (1) (b)]

Issued on this 12th day of December, 2013

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

Sherlee McKelly for Cathy Fedash