



**Ministry of Health and
Long-Term Care**

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

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**
**Division des foyers de soins de
longue durée**
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

**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**

Bureau régional de services de
Hamilton
119 rue King Ouest 11ième étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2016	2016_275536_0010	009009-16, 015767-16	Complaint

Licensee/Titulaire de permis

UNGER NURSING HOMES LIMITED
312 Queenston Street St. Catharines ON L2P 2X4

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

HAMPTON TERRACE CARE CENTRE
75 PLAINS ROAD WEST BURLINGTON ON L7T 1E8

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

CATHIE ROBITAILLE (536)

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): May 31 and June 1, 2016

009009-16 and 015767-16-responsive behaviours

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

The following Inspection Protocols were used during this inspection:



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**Reporting and Complaints
Responsive Behaviours**

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)**

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). 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.



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**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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the
reassessment and revision; and 2007, c. 8, s. 6 (11).**

**(b) if the plan of care is being revised because care set out in the plan has not
been effective, the licensee shall ensure that different approaches are considered
in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's plan of care was being revised because care set out in the plan has not been effective and different approaches have not been considered in the revision of the plan of care.

Resident #002 was admitted to the home on an identified date. A review of the resident's clinical record included an assessment by the Behavioural Support Ontario (BSO) which noted that the resident was exhibiting responsive behaviours. Resident #001 was admitted to the home on an identified date, and resident #002 began exhibiting behaviours towards resident #001. The BSO team identified various strategies to deter this behaviour which have not been totally effective. Different approaches have not been considered in the revision of the plan of care of resident #002. [s. 6. (11) (b)]

Issued on this 14th day of June, 2016

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



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Original report signed by the inspector.