

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 prévue le Loi de 2007 les foyers de soins de longue

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

Hamilton Service Area Office 119 King Street West, 11th Floor HAMILTON, ON, L8P-4Y7 Telephone: (905) 546-8294 Facsimile: (905) 546-8255 Bureau régional de services de Hamilton 119, rue King Ouest, 11iém étage HAMILTON, ON, L8P-4Y7 Téléphone: (905) 546-8294 Télécopieur: (905) 546-8255

## Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 24, 25, 26, 30, Aug 13, 15, 2012	2012_064167_0025	Complaint
Licensee/Titulaire de permis		
UNGER NURSING HOMES LIMITED 312 Queenston Street, St. Catharines, C Long-Term Care Home/Foyer de soin	······································	
HAMPTON TERRACE CARE CENTRE 75 PLAINS ROAD WEST, BURLINGTO	N, ON, L7T-1E8	`
Name of Inspector(s)/Nom de l'inspec	cteur ou des inspecteurs	
MARILYN TONE (167)		
Ins	pection Summary/Résumé de l'inspe	ection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered staff and personal support worker staff who had knowledge of the incident involving the identified resident related to Complaint Log # H-001127-12

During the course of the inspection, the inspector(s) reviewed the health records for the identified resident, reviewed the home's policy and procedure related to responsive behaviours, staff training records and any investigation notes completed by the home into the incident.

The following Inspection Protocols were used during this inspection: Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé
VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Alguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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)	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,

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours Specifically failed to comply with the following subsections:

- s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
- (a) the behavioural triggers for the resident are identified, where possible;
- (b) strategies are developed and implemented to respond to these behaviours, where possible; and
- (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

## Findings/Faits saillants:

- 1. S.53(4)b The licensee did not ensure that for each resident demonstrating responsive behaviours that strategies were developed and implemented to respond to these behaviours.
- a) When Resident # 001 was admitted to the home, the information provided on the Community Care Access Centre Minimum Data Set documentation indicated that the resident demonstrated a number of responsive behaviours prior to admission.
- b) The resident's plan of care did not identify any strategies or interventions to respond to or manage these potential behaviours until after the resident demonstrated an incident responsive behaviour that resulted in an injury.

## 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 that for residents who have displayed responsive behaviours that strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan Specifically failed to comply with the following subsections:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants:



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- 1. r. 24. (4) The licensee did not ensure that the care set out in the care plan for resident # 001 related to responsive behaviours was based on assessments and information provided by the placement co-ordinator under section 44 of the Act.
- a) Resident # 001 was noted on the Community Care Access Centre (CCAC), Minimum Data Set (MDS) documentation to have a history of responsive behaviours prior to admission to the home.
- b) It was also noted on the CCAC MDS documentation that Resident # 001 had a dislike.
- c) These potential behavioural triggers were not identified on the plan of care for the resident until after the resident had an incident of responsive behaviour.

Issued on this 29th day of August, 2012

narelysi Loxe

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