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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 21, 24, 2011	2011-173-2927-21Jan103311	Complaint Log # H03107

Licensee/Titulaire
St. Peter's Care Centres
125 Redfern Ave, Hamilton, Ontario L9C 7W9

Long-Term Care Home/Foyer de soins de longue durée
St. Peter's Residence at Chedoke
125 Redfern Ave., Hamilton, Ontario L9C 7W9

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – LTC Homes Inspector – Nursing - #173

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to falls management.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Registered Staff, Personal Support Workers, RAI Coordinator, and Physio Therapist.

During the course of the inspection, the inspector: Reviewed clinical health record, observed residents, reviewed policy and procedure.

The following Inspection Protocols were used during this inspection:
Falls Management Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s6(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.

Findings:

1. An identified resident who required a restraint to prevent self ambulation and falls received a change of equipment that did not have the specified restraint in place as required. The resident sustained a fall with injury as a result. The resident deceased 15 days after sustaining these injuries.

Inspector ID #:	173

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 related to ensuring all residents receive care as specified in the plan of care, to be implemented voluntarily.

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WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3(1)(11)(i)
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

Findings:

1. An identified resident who required a restraint to prevent self ambulation and falls received a change of equipment that did not have the specified restraint in place as required. The resident sustained a fall with injury as a result. The SDM (Substitute decision maker) for the resident was not contacted to participate in the development, implementation, review and revision of the plan and was unaware of the change and removal of the restraint until the resident sustained the fall.

Inspector ID #:	173

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 related to developing a process to ensure that residents are able to participate in the development, implementation, review and revision of his or her plan of care, to be implemented voluntarily.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lisa Wulff
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 22/11