



**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

Hamilton Service Area Office  
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Division de la responsabilisation et de la performance du  
système de santé  
Direction de l'amélioration de la performance et de la  
conformité

Licensee Copy/Copie du Titulaire  Public Copy/Copie Public

<b>Date(s) of inspection/Date de l'inspection</b> Dec 2, 3, 2010	<b>Inspection No/ d'inspection</b> 2010-173-2927-02Dec083948	<b>Type of Inspection/Genre d'inspection</b> Complaint Log #H00597 CIS Review Log # H00834
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**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 Inspector – Nursing - #173

**Inspection Summary/Sommaire d'inspection**

The purpose of this inspection was to conduct a complaint inspection and Critical incident review

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, RAI coordinator, registered staff, personal support workers (PSW's), residents and resident families.

During the course of the inspection, the inspector(s): Reviewed policy and procedure, reviewed resident clinical health records, and reviewed archived health records.

The following Inspection Protocols were used during this inspection:

- Falls Prevention Inspection Protocol
- Personal Support Services Inspection Protocol

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

- 2 WN
- 1 VPC

### NON- COMPLIANCE / (Non-respectés)

**Definitions/Définitions**

**WN** – Written Notifications/Avls 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 s.22(1)  
Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.**

**Findings:**

1. The Administrator of the home received a written letter of complaint in 2010. The letter of complaint was not forwarded to the Ministry of Health as required.

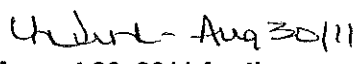
**Inspector ID #:** 173

**WN #2: The Licensee has failed to comply with O Reg 79/10, s24(9)(c)  
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised when  
(c) the care set out in the plan of care has not been effective.**

**Findings:**

1. A critical incident report was received by Hamilton Service Area office in 2010. An identified resident transferred from bed and sustained a fall with an injury. Upon review of the clinical record, this resident has a long standing history of self transfers, climbing out of bed, agitated behaviours that disturb sleep. Although the plan of care for this resident has been signed by staff as reviewed, reassessment and revision to the plan of care has not occurred. The plan of care for this resident has not been revised when the residents risk behaviors continued and care set out in the plan of care has not been effective.



Inspector ID #: 173	
<b>Additional Required Actions:</b>  <b>VPC</b> - pursuant to the <i>Long-Term Care Homes Act, 2007</i> , 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 a resident is reassessed and the plan of care reviewed and revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.	
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.   <b>Revised August 30, 2011 for the purpose of publication</b>
Title:	Date:
	Date of Report: (if different from date(s) of inspection).