

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: August 19, 2025

Inspection Number: 2025-1204-0002

Inspection Type:

Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: Hamilton Continuing Care, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7, 8, 12-13, 15, 18 and 19, 2025.

The following intake(s) were inspected:

-Intake: #00154769 - was related to Safe and Secure Home.

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviors

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

Responsive behaviours

s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee failed to ensure that the home's "Personal Expression Program" was complied with, specifically in written strategies, including techniques and interventions, to prevent, minimize or respond to a resident's responsive behaviours over a specified period of time in July 2025.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee of a long-term care home was required to have, institute, or otherwise put in place a program to ensure that the program was complied with.

The home's "Personal Expression Program" provided directions to staff to initiate and document the "Personal Expressions Neighbourhood Observation Tool" followed by the "PERT Assessment" to determine a level of risk of the situation and/or incident and to adjust a resident's plan of care based on the resident's care requirements.

A resident with specified cognitive skills had a history of responsive behaviors, which was confirmed by staff in the home.

A progress note indicated that the resident exhibited responsive behaviours but there was no PERT Assessment completed since the initial assessment of the resident.

The Director of Care (DOC) acknowledged that the resident was already on PE-RT

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Team case workload and was followed by the PE-RT Lead and agreed that there was a level of risk to the resident based on their responsive behaviour and the care plan was to be updated, since there were no specific directions documented to manage the resident's behavior documented in a progress note.

Sources: A resident's progress notes, written care plan and PE-RT assessment documentation; interviews with staff, the PE-RT Lead and the DOC.