Ontario

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
***Fixing Long-Term Care Act, 2021***

**Hamilton Service Area Office**
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**Original Public Report**

**Report Issue Date** June 24, 2022
**Inspection Number** **2022_1331_0001**
**Inspection Type**
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
Unger Nursing Homes Limited

**Long-Term Care Home and City**
Hampton Terrace Care Centre
75 Plains Road West
Burlington, Ontario
L7T 1E8

**Lead Inspector**
Lesley Edwards #506

**Inspector Digital Signature**
Lesley E Edwards
Digitally signed by Lesley E Edwards
Date: 2022.06.28 15:05:36 -04'00'

## INSPECTION SUMMARY

The inspection occurred on the following date(s): June 8, 9, 10, 13, 14, 15, 16, 17, 20 and 22, 2022.

The following intake(s) were inspected:

- Log 015543-21- related to falls prevention and management.
- Log 013181-21- related to falls prevention and management.
- Log 001871-22- related to falls prevention and management.
- Log 017213-21- for a complaint related to prevention of abuse and neglect.

Inspectors Stephanie Smith #740738 and Emma Volpatti #740883 participated in this inspection as observers.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Safe and Secure Home

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: BINDING ON LICENSEES

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

**Non-compliance with: FLTCA, 2021 , s.** 184 (3)

The licensee has failed to ensure that the home carried out the COVID-19 screening tool for Long-Term Care Homes and Retirement Homes as set out in Directive #3.

Chief Medical Officer of Health (CMOH)'s Directive #3 required homes to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, as per the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes.

The COVID-19 Screening Tool for Long-Term Care Homes directed at a minimum, that all individuals entering the home were actively screened using specific questions. This included reviewing each symptom (ten in total) and asking a set of six questions related to their possible exposure to COVID-19.

**Rationale and Summary**

On an identified date in June 2022, the Long- Term Care Homes (LTCH) Inspectors #506, #740738 and #740883 were allowed into the home by a screener. The Inspectors were asked if they had any general symptoms of COVID-19; however, were not asked the specific questions as outlined in the screening tool. Inspectors were not asked if they were instructed to self -isolate by a doctor, health care provider or public health unit, if they were in close contact (or lived) with someone with COVID-19 symptoms or who tested positive for COVID-19 and if they tested positive on a rapid antigen test or a home-based self-testing kit, or whether they lived with someone who was waiting for COVID-19 test results.

When individuals were not actively screened at the entrance, it may have increased the risk that someone carrying the virus could enter the facility, causing potential risk of harm to residents.

Sources: Observations of entrance screening; CMOH's Directive #3, effective March 18, 2022, COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes Version 10; and interview with screener and Infection Prevention and Control Manager (IPAC). [#506]

## WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

**NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 79/10, s. 36**

The licensee has failed to ensure that staff used safe techniques when transferring a resident.

**Rationale and Summary**

On an identified date in October 2021, a personal support worker (PSW) instructed another PSW to transfer the resident by themselves. The resident's plan of care identified that the resident required a specific method for all transfers.

The PSW did not use safe transferring techniques as they should not have used a Substitute Decision Maker (SDM) as a second person for transferring; the Director of Nursing (DON) acknowledged that all transfers should be completed by staff.

Failure to transfer residents following their assessed needs, plan of care, and without training had the potential to result in an injury to the resident.

Sources: A resident's clinical record, the home's investigation notes and interview with the DON. [#506]