Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: August 22, 2023	
Inspection Number: 2023-1331-0004	
Inspection Type: Critical Incident	
Licensee: Unger Nursing Homes Limited	
Long Term Care Home and City: Hampton Terrace Care Centre, Burlington	
Lead Inspector Meghan Redfearn (000765)	**Inspector Digital Signature** Meghan Redfearn Digitally signed by Meghan Redfearn Date: 2023.09.05 11:03:15 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 10-11, 14-16, 2023.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00090006/CI #2846-000008-23 - related to Responsive Behaviours
- Intake: #00091366/CI #2846-000009-23 - related to Falls Prevention and Management

Inspector Dusty Stevenson (740739) was also present during inspection.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's plan of care set out clear directions to staff related to an intervention.

Rationale and Summary:

A review of a resident's progress notes indicated an intervention was initiated and the care plan was updated on an identified date. During a review of the resident's care plan it did not include the intervention.

A staff member acknowledged that staff are made aware of a resident's need for an intervention by looking at the care plan and acknowledged that the intervention should have been in place while the resident was in their room during the day and at night. A second staff member acknowledged that the intervention was used in the evenings. A third staff member acknowledged that the intervention was used at any time of the day but mostly in the evenings.

Inspector #000765 observed the resident's room on two different dates while the resident was in bed. The intervention was observed as present but was not in use on each observation.

A staff member acknowledged that the intervention should be in the care plan so that clear direction is provided to staff on when to use it.

On a later date, the resident's care plan was updated to reflect staff to ensure the intervention is in place when the resident is in their room.

Sources: resident care plan; resident progress notes; interview with staff members; observation of resident's room.

[000765]

Date Remedy Implemented: August 16, 2023