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 District
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Original Public Report

Report Issue Date: November 21, 2023
Inspection Number: 2023-1331-0006
Inspection Type: Complaint Critical Incident
Licensee: Unger Nursing Homes Limited
Long Term Care Home and City: Hampton Terrace Care Centre, Burlington

Lead Inspector	**Inspector Digital Signature**
Lisa Vink (168)	Lisa Vink Digitally signed by Lisa Vink Date: 2023.11.28 11:12:26 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 18, 19, 23, 24, 25, 26, 27, 30, 2023, November 1, 8, 9, 2023, and offsite on November 2, 2023.

The following intakes were inspected:

- Complaint intake #00092135 related to plan of care, medication administration, continence care and the complaints process.
- Critical Incident (CI) Report Intake #00093126 related to falls prevention and management.
- Complaint Intake #00097911 related to bedrails, staff training and sleep and rest routines.
- CI Report Intake #00099263 related to injury of unknown origin.

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

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards
Reporting and Complaints
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) (a)

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident.

Rationale and Summary
A resident used equipment to meet a care need.

The equipment was to be secured to be used safely, due to a risk situation.

The plan of care did not initially include the need to secure the equipment.

On October 26, 2023, the plan of care was revised, and staff were informed of the need to ensure that the equipment was secured.

Sources: Observations of the resident and their equipment and interviews with the staff and others. [168]

Date Remedy Implemented: October 26, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee has failed to ensure that when a resident was reassessed and the plan of care was revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

Rationale and Summary
A resident required a level of assistance in bed and interventions for bed safety.

On admission they were assessed and were provided with personal assistance services devices to assist with their activities of daily living. Additional measures were also implemented to support positioning, communication, and safety.

On the resident's request, their bed system was reassessed, and alterations were made for their comfort.

Additional modifications were made to the bed system to support the resident; however, these were completed without approval or in consultation with the home.

The resident remained unsatisfied with their bed system and continued to voice concerns.

Reassessments of the resident and their bed system, in response to the concerns, resulted in the implementation of additional interventions; however, different approaches, which were not readily available in the home, were not considered.

Failure to consider different approaches in the reassessment of the resident and their bed system resulted in undesired modifications, reported resident discomfort and potential risk.

Sources: Interviews with and observations of a resident in bed and their bed system, record review including assessments, progress notes and plan of care and interviews with the staff. [168]

WRITTEN NOTIFICATION: Personal Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36

The licensee has failed to ensure that a resident received individualized personal care, including hygiene care and grooming, on a daily basis.

Rationale and Summary
A resident required a level of assistance of staff to meet their grooming needs.

The resident's hair was observed unkempt, suggestive that grooming was not completed on a daily basis.

Staff confirmed that the resident could be resistant to having hair care completed at times and that their grooming needs were not met when observed on a specific day.

A review of the records did not include that the resident refused grooming during the identified time.

Sources: Review of the plan of care and point of care records for a resident, observations and interviews with the resident and staff. [168]