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

Original Public Report

Report Issue Date: May 16, 2023	
Inspection Number: 2023-1331-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Unger Nursing Homes Limited	
Long Term Care Home and City: Hampton Terrace Care Centre, Burlington	
Lead Inspector Lesley Edwards (506)	**Inspector Digital Signature** Lesley E Edwards Digitally signed by Lesley E Edwards Date: 2023.05.25 14:30:35 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 5, 8, 9, 10, 11 and 12, 2023.

The following intakes were inspected:

- Intake: #00018235 - Critical Incident (CI)- falls prevention
- Intake: #00018267 - Complaint- related to transferring and positioning, plan of care, skin and wound care and prevention of abuse and neglect

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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 there is a written plan of care for a resident that set out the planned care for the resident.

Rationale and Summary
Observation in May 2023, and discussion with staff identified that a resident had been trialing a new intervention for seven days while being transferred with the mechanical lift. Review of the written care plan which front line staff used to direct care, did not include the new intervention to be used. The resident's written care plan was updated with the new intervention being trialed.

Sources: Observation; record review of a resident's plan of care; interview with Director of Nursing (DON) and other staff.
[506]

Date Remedy Implemented: May 10, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment with respect to safety risks.

Rationale and Summary

A resident had sustained several injuries while care was being provided. Registered staff sent a referral to the physiotherapist on an identified date in February 2023, to complete an assessment of the resident related to the injuries.
Record review and interview with the physiotherapist confirmed that the referral was not completed and there was not an interdisciplinary assessment of the resident related to the safety risks while care was being provided.

Sources: A resident's clinical record; physiotherapist referral and interview with physiotherapist and other staff.
[506]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident, who exhibited altered skin integrity, received a skin assessment by a member of registered nursing staff upon any return of the resident from hospital.

Rationale and Summary
A resident was sent to the hospital for an assessment on an identified date in January 2023, a review of the clinical record confirmed that a skin and wound assessment was not completed upon their return from the hospital.

Sources: A resident's clinical record; the home's policy Skin/Wound Care program reviewed July 2022; Interview with the skin and wound lead and other staff.
[506]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they were assessed by a registered dietitian (RD).

Rationale and Summary

On identified dates in January and February 2023, a resident's progress notes identified they had new areas of altered skin integrity. A review of the resident's clinical record did not include a RD assessment, or a nutritional referral related to the new areas of altered skin integrity. The RD acknowledged they should have been sent a referral and an assessment should have been completed.
The resident could have been at risk for inadequate nutrition related to their altered areas of skin integrity, when the RD did not assess the resident's nutritional care needs.

Sources: A resident's clinical record; the home's policy Skin/Wound Care program reviewed July 2022; Interview with RD and other staff.
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