Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2019	2019_505103_0004	008491-18, 001360-19, 001516-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Hallowell House
13628 Loyalist Parkway PICTON ON K0K 2T0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 31, February 4-6, 8, 2019.

**Log #008491-18 (CIS #0891-000004-18)-resident fall that resulted in an injury,
Log #001360-19 (CIS #0891-000001-19)-alleged incident of staff to resident incompetent care/treatment,
Log #001516-19 (CIS #0891-000002-19)-alleged incident of resident to resident abuse.**

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Nurse (RN), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the critical incidents submitted by the home and the home's investigation into the alleged incidents of incompetent care/treatment and abuse.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to resident #002 as outlined in the plan.

On an identified date, PSW's #107 and #108 were assisting resident #002 with a bath and grooming. PSW #107 witnessed PSW #108 suddenly pulling a pad out from under resident #002 while the resident was seated. The resident reacted by screaming.

Resident #002's plan of care, in effect at the time of this incident, was reviewed and indicated the following:
-staff assist to rise from sitting to standing positions slowly,
-requires weight bearing assistance (extensive) for transfer with a pivot/turn disk and 1 staff,
-requires weight bearing assistance (extensive) for peri-care with 1-2 staff, and
-explain and demonstrate each activity/care procedure prior to beginning and throughout procedure.

The DOC was interviewed and indicated PSW #108 had stated they thought the resident would have been too weak to stand up again and therefore, attempted to remove the pad while the resident was seated. The DOC stated resident #002 had used a sit to stand lift with the assist of 2 staff in the past and that regardless of the PSW's thoughts, there were no attempts made to provide care in accordance with the resident's plan of care.

The DOC indicated a head to toe assessment was completed upon being made aware of the incident and the resident did not sustain any skin impairments as a result of the PSW's actions. [s. 6. (7)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect an incident of incompetent treatment or care involving resident #002 failed to report the suspicion immediately to the Director.

As outlined in WN #1, an incident occurred on an identified date while PSW's #107 and #108 were providing care to resident #002.

Four days later, PSW #107 reported the incident for the first time to the DOC. The home immediately reported the incident to the Director (MOHLTC) and investigated the allegation. PSW #107 stated they were aware the incident should have been immediately reported and was unable to provide a reason for the delay. [s. 24. (1)]

Issued on this 13th day of February, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.