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
May 1, 2019	2019_664602_0021	007692-19	Complaint

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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 15 & 16, 2019

Complaint Log# 007692-19 - regarding fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident/Family Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), a Restorative Aid, Personal Support Workers (PSW) and family. In addition, observations of resident care service delivery, and reviews of the electronic and hard copy record, incident reports, admission documentation including a behavioural assessment, as well as a post fall observations report, and relevant policies/procedures were completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

In accordance with O. Reg. 79/10, s. 48, the licensee was required to ensure that a falls prevention and management program that reduces the incidence of falls and the risk of injury is developed and implemented in the home: Specifically, staff did not comply with the licensee's CARE5P10 - Falls Prevention and Injury Reduction policy which is part of the licensee's Falls Prevention and Management program.

In interviews with the Administrator on April 15, 2019, and the Director of Care (DOC) #110, on April 18, 2019, it was indicated that as part of their Falls Prevention and Injury Reduction policy, where there is significant injury to a resident, the "Significant Resident Injury" checklist is completed; the checklist includes direction under item 7., call the MOH and in 8., initiate a CIS.

On a specified date at a specified time, resident #001 was found in their room laying on the floor. The resident was unresponsive with possible injury. An assessment was completed and the resident was sent to hospital where an injury was identified. The physician and family were notified. There was no indication that the Director was alerted, nor was a Critical Incident System (CIS) report initiated.

The licensee did not comply with their Fall Prevention and Reduction policy which is part of the home's Falls Prevention and Management program. [s. 8. (1) (a),s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the occurrence of an incident that caused an injury to resident #001 that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

On a specified date, at a specified time, resident #001 was found laying on the floor. An assessment was completed and found the resident to be unresponsive, with a possible injury. Resident#001 was transferred to hospital where an injury was identified. The resident was palliated in hospital and passed away on the following day.

The physician and family were notified, however, there was no indication that the Director was alerted to the critical incident (CI), until notification, by a complainant, seven months later. A review of the Ministry of Health and Long-Term Care's CI reporting system revealed that a critical incident report was not submitted for this incident. The Administrator was interviewed and confirmed that it appeared that they did not report the critical incident as required by O. Reg. 79/10, s. 107 (3). [s. 107. (3) 4.]

Issued on this 1st day of May, 2019

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

Original report signed by the inspector.