

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007****Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée****Long-Term Care Operations Division  
Long-Term Care Inspections Branch****Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**Ottawa Service Area Office  
347 Preston St Suite 420  
OTTAWA ON K1S 3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670Bureau régional de services d'Ottawa  
347 rue Preston bureau 420  
OTTAWA ON K1S 3J4  
Téléphone: (613) 569-5602  
Télécopieur: (613) 569-9670**Public Copy/Copie du rapport public**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 6, 2020	2020_505103_0001	022914-19, 023303- 19, 023364-19	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**

DARLENE MURPHY (103)

**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): January 16, 17, 20, February 3, 2020.**

**Log #022914-19-written letter of complaint,  
Log #023303-19 and Log #023364-19-complaints related to resident care.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC), the Director of Care (DOC), the Acting Administrator and the Administrator.**

**During the course of the inspection, the inspector reviewed resident health care records, the long-term care home's documented record of complaints, home's investigation into the complaints, relevant critical incidents submitted by the long-term care home and policies related to abuse, diabetic management and the complaints process.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation  
Reporting and Complaints**

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

**4 WN(s)**

**3 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
  - (b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
  - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure resident #001 was assessed when resident #001's care needs changed.

On an identified date, resident #001 was struck by resident #003. PSW #101 witnessed the incident and was interviewed. PSW #101 stated resident #001 reported having pain following the incident and requested analgesics. PSW #101 stated the incident was immediately reported to RPN #102.

RPN #102 was interviewed and stated they were advised of the incident but did not complete an assessment of resident #001 at that time to determine if they had injuries. RPN #102 stated the resident had stated they were fine.

Resident #001's medication administration record for the identified month was reviewed. Resident #001 received two prn (as required) doses of analgesics following this incident. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure residents are assessed when their care needs change, to be implemented voluntarily.***

---

**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 resident #001 was being financially abused failed to immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, RPN #102 observed resident #002 with resident #001's debit/credit card and overheard resident #002 attempting to set up services for themselves using resident #001's card. RPN #102 stated they believed resident #002 was trying to use resident #001's card without proper authority and believed this constituted financial abuse as resident #002 was known to have similar behaviours with other residents. RPN #102 stated they contacted resident #001's Power of Attorney (POA) to notify them of the incident but did not report the incident immediately to anyone else. [s. 24. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect resident abuse immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference**

**Specifically failed to comply with the following:**

**s. 27. (1) Every licensee of a long-term care home shall ensure that,**  
**(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).**  
**(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).**  
**(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure a care conference of the interdisciplinary team providing resident #001's care was held within six weeks following resident #001's admission.

Resident #001's health care record was reviewed and there was no documentation to support the completion of a care conference. ADOC #105 was interviewed and stated care conferences had been cancelled related to staffing vacancies at that time. [s. 27. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**

**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**

**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**

**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**

**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**

**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**

**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure a documented record was kept in the home that included the nature of each written complaint.

On an identified date, a written letter of complaint was submitted to the home outlining concerns related to the home's environment, staffing and food quality. Administrator #112 was interviewed in regards to the actions taken by the home to address the concerns and the home's documented record of complaints for 2019 was reviewed. This written letter of complaint was not included in the documented record. Administrator #112 indicated they were aware it should have been included and believed it was an oversight that it had not been included. [s. 101. (2)]

**Issued on this 6th day of February, 2020**

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

**Original report signed by the inspector.**