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

Ottawa District
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Original Public Report

Report Issue Date: February 17, 2023	
Inspection Number: 2023-1001-0002	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Hallowell House, Picton	
Lead Inspector Cathi Kerr (641)	**Inspector Digital Signature** Cathi Kerr Digitally signed by Cathi Kerr Date: 2023.02.23 17:17:16 -05'00'
Additional Inspector(s) Carrie Deline (740788)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7, 8, 9, 13, 2023

The following intake(s) were inspected:

- Intake: #00009079 - CIS #0891-000018-22; Intake: #00009271 -CIS #0891-000019-22; Intake: #00011440 - -CIS #0891-000023-22; and Intake: #00019098 - CIS #0891-000006-23 related to alleged resident to resident sexual abuse.
- Intake: #00011475 -CIS #0891-000022-22 related to alleged staff to resident sexual abuse.
- Intake: #00014786 - CIS #0891-000027-22: related to alleged staff to resident physical abuse.
- Intake: #00015823 - CIS #0891-000030-22 related to an Injury to a resident of unknown cause.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that abuse or neglect of a resident by anyone including staff, that results in harm or a risk of harm to the resident, be immediately reported to the Director. Specifically, the Licensee failed to report a suspicion of abuse immediately after being made aware of the allegation.

Rationale and Summary:

A review of a resident's health care record indicated an allegation of staff to resident physical abuse was reported to the Registered Nursing staff by the resident.

Interviews with the Assistant Director of Care (ADOC) and the Administrator confirmed that the incident was reported to a Registered Nursing staff and was not reported to the Director immediately. The incident was reported to the Director three days later when management was informed of the incident.

Failure to immediately report incidents of alleged abuse or neglect puts residents at risk of additional harm.

Sources: Critical Incident, Record Review, Interviews with Administrator and ADOC. [740788]