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
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: April 26, 2023	
Inspection Number: 2023-1001-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Hallowell House, Picton	
Lead Inspector Carrie Deline (740788)	**Inspector Digital Signature** Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.04.28 13:25:48 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17 - 21, 2023

The following intake(s) were inspected:

- Intake: #00021913 - CIR# 0891-000011-23: Environmental hazard - No hot water
- Intake: #00022195 - CIR# 0891-000012-23 Resident fall with injury.
- Intake: #00022293 -Complainant regarding transferring and CIR reporting
- Intake: #00022989 - CIR# 0891-000015-23 Resident fall with injury.
- Intake: #00085553 - CIR# 0891-000022-23 Alleged resident neglect.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that toileting was completed as set out in the plan of care for a resident.

Rationale & Summary

A Critical incident report submitted to MLTC indicated that a staff member left a resident for a period of time unattended on the toilet. A review of resident's plan of care at time of incident indicated that the resident was to be toileted with one to two staff assistance. The resident was also to be provided privacy but have staff remain in the immediate area during toileting.
Interviews with staff and resident confirm that the resident does require staff assistance and is unsafe to have staff not remain in the immediate area during toileting.

Failure to follow a resident's plan of care places a resident at risk for not being provided the care they require.

Sources:

Resident progress note and care plan; CIS 0891-000022-23, Resident observations, and interviews with DOC, RAI Coordinator, and PSW's.
[740788]