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: July 7, 2023	
Inspection Number: 2023-1001-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Hallowell House, Picton	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.07.07 12:24:29 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30, 31 and June 1, 2, 5, 6, 8, 9, 2023

The following intake(s) were inspected:

- Intake: #00084166/CIS #0891-000020-23 - regarding Infection Prevention & Control practices (IPAC), improper care and dining and snack services.
- Intake: #00086659 & #00087594/CIS #0891-000024-23 & #0891-000025-23 - regarding falls with injury requiring transfer to hospital.
- Intake: #00086934 - complaint regarding alleged neglect/improper care.

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to comply with their written policy to promote zero tolerance of abuse and neglect of three residents.

Rationale and Summary:

For the purposes of the Act: "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In interviews with the Director of Care and Regional Manager it was confirmed that two residents were not assisted to eat as outlined in their plan of care, resulting in neither of them eating a dinner meal. In addition, video footage showed several Personal Support Worker (PSW) staff and a Registered Practical Nurse (RPN) eating resident food at resident tables. Staff were aware that the licensee considers unauthorized consumption of resident food to be financial abuse; this is outlined in their orientation and annual abuse/neglect policy education. Investigation into the events of that evening also noted that another resident was not assisted to toilet and sat in their own feces during their dinner meal despite staff awareness that the resident had been incontinent.

Failure to comply with the licensee's policy regarding Zero Tolerance of Abuse and Neglect of Residents jeopardized the health, safety and well-being of multiple residents.

Sources:

A Critical incident System (CIS) report, investigation documentation, abuse (financial) education slides, Administration policy: LTC - Resident Non-Abuse Analysis and Education, video footage and interviews with the Administrator, DOC and the Regional Manager. [602]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that a resident's written plan of care set out clear direction to staff and others who provide direct care to the resident.

Rationale & Summary:
A resident had an unwitnessed fall and was transferred to hospital for further assessment of an injury. A review of the care plan in place and multiple observations at the time of inspection found conflicting transfer status and mobility requirements; the written care plan indicated the resident was ambulatory with a walker and could transfer with the assistance of one staff. The in room transfer logo noted that the resident was to be transferred using a walker and the assistance of two staff. Interviews and observations indicated that resident was in a wheelchair and required extensive assistance of two staff to transfer. Unclear direction could place the resident at an increased risk for falls.

Sources:
A CIS report, resident progress notes, care plan, multiple observations and interviews with the Assistant DOC, PSWs and other staff. [602]

WRITTEN NOTIFICATION: NURSING AND PERSONAL SUPPORT SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45
The licensee failed to ensure four residents, were supported in their desired bedtime routine(s).

Rationale and Summary:
The Administrator advised and the DOC #101 confirmed that an investigation into an incident found that four residents were assisted to bed between 1800 and 1900 hours despite care plans that indicated their preferred bedtimes were between 2000 and 2200 hours. Investigation documentation indicated that staff confirmed these residents were usually assisted to bed directly after dinner.

Sources:
A CIS report, investigation documentation, resident care plans, video footage and interviews with the Administrator and the DOC. [602]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
The licensee failed to ensure a resident received a regular diet with minced texture.

Rationale and Summary:

The Administrator advised and the DOC confirmed that an investigation into an incident found that a resident began to eat a regular vs. minced texture meal. Video footage of the dinner service showed the resident initially eating from a regular texture plate; this was noticed by a PSW who replaced the plate with a minced texture meal. The resident subsequently began to spit out their food. The PSW then substituted the minced texture meal with a pureed meal, the change in texture was not documented. The resident's care plan indicates the resident is to receive a regular diet with minced texture.

Failure to ensure a resident receives the appropriate diet texture increases choking and nutritional risks.

Sources:
A CIS report, investigation documentation, resident care plan, video footage and interviews with the Administrator and DOC. [602]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
The licensee failed to comply with their written policy related to food and fluid intake monitoring for residents with identified risks related to nutrition and hydration.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that their written policy related to food and fluid intake monitoring was complied with.

Specifically, PSW staff did not comply with the roles and responsibilities outlined in the hydration management – intake monitoring policy: document resident intake and output.

Rationale and Summary:
The Administrator and the DOC #101 confirmed that an investigation into an incident found that a PSW documented a resident's fluid intake during the evening meal as 180 mls when video footage showed the resident was not provided with any fluids during dinner. The same PSW documented a second resident's meal intake at 25-50% when their intake was 75-100%, and their fluid intake as 360 mls when the resident was not offered anything to drink with their meal; receiving only water with their medication. In addition, the PSW documented that another resident's fluid intake during dinner was 375 mls however this resident was not given any fluids and only received water with their medication. A fourth resident was documented as having consumed 75-100% of their snack and 180 ml’s of fluid when they were not actually

offered a snack or fluids that evening. It was also found that fourteen of the eighteen residents on the unit did not have their evening snack intake documented.

Failure to document food and fluid intake accurately increases resident nutritional and dehydration risks.

Sources:
A CIS report, investigation documentation, Long-Term Care food and fluid intake monitoring policy, resident care plans, video footage and interviews with the Administrator and the DOC. [602]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (8)
The licensee failed to ensure beverages, including water, that are appropriate for the residents' diets were available to five residents at dinner.

Rationale and Summary:
In interviews, the Administrator and DOC advised that an investigation into an incident found that five residents were not offered a beverage during dinner despite the fact that their care plans indicated they have inadequate fluid intake.

Failure to ensure beverages were available to residents at the dinner meal increased their dehydration and nutritional risk.

Sources:
A CIS report, investigation documentation, resident care plans, video footage and interviews with the Administrator and DOC. [602]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 6.
The licensee failed to ensure that four residents were given sufficient time to eat at their own pace.

Rationale and Summary:
The Administrator advised and the DOC confirmed that an investigation into an incident found that four residents were not able to eat at their own pace.

Video footage and investigation documentation of a dinner service showed a PSW staff attempting to feed a resident who had been eating independently. Four minutes later the resident's plate was removed and they were taken out of the dinning area without being offered dessert.

Video footage further revealed that another resident, who had refused to leave the dining area, was assisted to stand and walked quickly out of the dining room by two PSW staff. The resident had difficulty keeping up with the staff and leaned backwards while shuffling their feet forward, struggling to keep up. The resident was not offered dessert prior to being assisted out of the dining room.

Another PSW staff was observed giving a resident food when they were still chewing on their last mouthful. The resident pushed the food away and the PSW subsequently put another forkful against the resident’s mouth. The PSW was also noted putting an overloaded fork in front of the resident’s mouth while the resident was feeding themselves; the resident flinched; the PSW then put more food against resident's mouth while they were still chewing.

Failure to ensure sufficient time for a resident to eat at their own pace increases choking and nutritional risks as well as decreases the resident’s pleasurable dining experience.

Sources:
A CIS report, investigation documentation, video footage and interviews with the Administrator and DOC. [602]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
The licensee failed to ensure that three residents were assisted to eat using proper technique.

Rationale and Summary
The Administrator advised and the DOC confirmed that an investigation into an incident found that three residents were assisted to eat by staff without using proper technique.
Video footage and investigation documentation regarding the dinner service showed:

- A PSW feeding a resident from a standing position.
- A RPN feeding another resident from a seated position while the resident was standing.
- A PSW standing over top of a third resident attempting to feed them from behind.
- A PSW attempted to feed a fourth resident, who was eating their dessert independently; this resident was not positioned properly in their chair.

Failure to ensure proper technique while assisting residents to eat increases choking and nutritional risks, as well as decreases the resident's pleasurable dining experience.

Sources:
A CIS report, investigation documentation, video footage and interviews with the Administrator and DOC. [602]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL (IPAC)

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
The licensee failed to ensure that infection prevention and control (IPAC) standards issued by the Director, with respect to:

- Hand hygiene – residents and staff and
- Masking – staff,

were complied with.

Rationale and Summary:
A review of video footage revealed several PSW's and a RPN entering and exiting a dining area without performing hand hygiene or assisting residents to perform hand hygiene. Staff were also observed wearing their masks underneath their chin or not at all. In addition, these staff did not perform hand hygiene in between assisting residents to eat, eating a meal themselves at resident tables, interacting with multiple residents and/or moving from resident table to resident table. Interviews with the Administrator, DOC and the IPAC lead as well as investigation documentation noted that staff had been trained on/were aware of hand hygiene and masking standards outlined in the home's hand hygiene policy and the universal mask strategy for staff residents and visitors used in the home to guide masking practices.

Failure to mask, support resident hand hygiene practices and perform own handwashing while caring for residents increases the risk of virus transmission among residents and staff.

Sources:
A CIS report, investigation documentation, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes – Hand hygiene additional requirements, Licensee policy: Routine

Practices and Additional Precautions – Hand hygiene, Universal Mask Strategy for staff, residents and visitors and interviews with the Administrator, DOC and the IPAC lead. [602]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (c)
The licensee failed to ensure five residents were offered an evening snack.

Rationale and Summary:
The Administrator and the DOC advised that during an investigation into an incident they found that five residents were not offered an evening snack as they had already been assisted to bed. A review of the plans of care for two of the residents noted that both were assessed as at high nutritional risk; the plan of care for the remaining three residents indicated they were at moderate nutritional risk. In addition, the care plan for each of these residents indicated they have inadequate fluid intake.

Failure to ensure these residents were offered a snack at hs increased their dehydration and nutritional risk.

Sources:
A CIS report, investigation documentation, resident care plans, video footage and interviews with the Administrator and DOC. [602]