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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: September 20, 2023	
Inspection Number: 2023-1001-0006	
Inspection Type: Complaint Critical Incident	
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: 2023.09.21 07:28:56 -04'00'
Additional Inspector(s) Patricia OBrien 000730)	

INSPECTION SUMMARY

The following intake(s) were inspected:

- Intake # 00090781/CI#0891-000033-23 - regarding a fall with injury and transfer to hospital.
- Intake #00091495/CI#0891-000035-23 - regarding an unexpected death.
- Intake #00091789 - complaint regarding nutritional care; inappropriate dietary changes.
- Intake: #00092155/CI#0891-000037-23 - regarding alleged resident to resident sexual abuse.

The following intake(s) were completed in this inspection:

- Intake # 00093806/CI#0891-000038-23, Intake # 00089864/CI#0891-000030-23, Intake # 000090212/CI#0891-000031-23 - regarding falls with injury and transfer to hospital.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (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's care plan outlined they were to be provided with a regular diet with a specific modified texture, however interviews with the family, nursing and food services staff indicated the resident was to receive a different modified texture diet. Record reviews and observations confirmed the different texture diet had been ordered/was provided. Unclear direction regarding diet texture could place residents at an increased risk for choking and inadequate intake.

Sources:
Resident progress notes, diet orders, dining observations, interviews with the family, Dietary Aids, a Registered Practical Nurse and a cook [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 (7)

The licensee failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rational & Summary:
A review of a critical incident report indicated that a resident sustained an injury after falling. Post fall, the resident's care plan identified the use of wheelchair for most mobility; it further identified that the chair could be tilted to a maximum of thirty (30) degrees for comfort and positioning. The resident was observed in their wheelchair tilted at greater than 30 degrees. In subsequent interviews the Director of

Care and a Personal Support Worker confirmed that the resident should be tilted at maximum of 30 degrees as per the plan of care.

The resident was at risk for falls; a greater than 30 degree tilt put the resident at further risk for falls should they try to get out of their chair.

Sources:
Critical incident report, plan of care, interviews with the Director of Care, a personal support worker and resident observations [000730].

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