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: February 8, 2024

Inspection Number: 2024-1001-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Hallowell House, Picton

Lead Inspector	**Inspector Digital Signature**
Wendy Brown (602)	Wendy K Brown Digitally signed by Wendy K Brown Date: 2024.02.09 13:21:33 -05'00'

Additional Inspector(s)
Ashley Bernard-Demers (740787)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 24, 29, 30, 31, 2024 and February 1, 2, 6, 7, 2024. The inspection occurred offsite on the following date(s): January 26, 2024

The following intake(s) were inspected:

- Intake: #00094861/CIS #0891-000040-23 - regarding alleged resident to resident physical abuse.
- Intake: #00094894/CIS #0891-000041-23 - regarding alleged resident to resident physical abuse.
- Intake: #00097884/CIS #0891-000044-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00098611/CIS #0891-000045-23 - regarding alleged resident to resident physical abuse.

- Intake: #00098767/CIS #0891-000047-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00099024/CIS #0891-000048-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00104274 - Complaint regarding sufficient staffing.
- Intake: #00108097 - Complaint regarding alleged staff to resident neglect.

The following intake was completed in this inspection: Intake #00098767/CIS #0891-000047-23 was related to falls.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
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)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that support care was provided to a resident on two separate shifts.

Sources: Resident progress notes and care plan, and interviews with the RAI coordinator, Director of Care and the resident services clerk. [602]

WRITTEN NOTIFICATION: Reporting and Complaints

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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:

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.

The licensee failed to immediately report an incident of alleged neglect of a resident to the Director.

Sources: Action line call, triage call, and an interview with the DOC. [602]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2)

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.

7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that a personal support worker (PSW) received orientation training prior to beginning working at the home..

Sources: Review of staff names and start dates for the months of June, July, and August, review of a document entitled "Orientation sign offs"; an interview with a PSW and the DOC. [740787]