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

Central West District
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Original Public Report

Report Issue Date: May 26, 2023	
Inspection Number: 2023-1264-0002	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Trillium Court, Kincardine	
Lead Inspector Kristen Owen (741123)	**Inspector Digital Signature** Kristen A Owen Digitally signed by Kristen A Owen Date: 2023.05.26 14:29:12 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 17-18, 2023

The following intake(s) were inspected:

- Intake: #00021415 and intake: #00022225 related to allegations of abuse of a resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to immediately investigate an incident of alleged abuse towards a resident.

Rationale and Summary
Personal Support Worker (PSW) #105 reported an allegation of abuse towards a resident from PSW

#107 to the Director of Care (DOC). The DOC did not immediately investigate the incident but stated they should have.

The allegations of abuse were not investigated by the home until two days later.

Failing to investigate the alleged abuse immediately, posed a risk to the resident's safety and could have prevented the resident from receiving treatment if there were any injuries or harm identified from the alleged incident.

Sources: Interviews with PSW #105, Executive Director (ED) #101 and DOC #100; the home's investigation notes

[741123]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 suspicions of abuse of a resident were immediately reported to the Director.

Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary
A) PSW #102 reported an allegation of physical and verbal abuse of a resident by PSW #107. They first reported this to Registered Nurse (RN) #106. PSW #102 then reported this to Registered Practical Nurse (RPN) #103 and RN #108 on the same day.

Five days later, PSW #102 reported the allegations of abuse to the DOC and ED, and the Critical Incident (CI) report was submitted to the Director on the same day.

RN #106 said they are to report suspected abuse immediately and that they should have reported this to management in the home.

Failing to report the allegations of abuse to the Director immediately, posed a risk to the resident as it could have prevented the Director from intervening if necessary.

Sources: The home's investigation notes; interviews with RN #106, PSW #102 and ED #101; Resident Non-Abuse Policy, ADMIN1-P10-ENT, effective date LTC: August 31, 2016, reviewed date: March 31, 2017; Resident Non-Abuse Procedure, ADMIN-O10.01, effective date: August 31, 2016, reviewed date: March 31, 2023

[741123]

B) PSW #105 alleged PSW #107 abused a resident while providing care. They did not report the allegation to RN #109 and the DOC until several hours later.

RN #109 stated they would have reported this to the DOC; however, the DOC was present in the room at the time PSW #105 reported it. The DOC did not report this to the Director.

The CI was not submitted to the Director until 14 days after the alleged incident. The ED said it was not reported as required.

Failing to report the allegations of abuse to the Director immediately, posed a risk to the resident as it could have prevented the Director from intervening if necessary.

Sources: The home's investigation notes; interviews with PSW #105, ED #101, DOC #100; Resident Non-Abuse Procedure, ADMIN-O10.01, effective date: August 31, 2016, reviewed date: March 31, 2023

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