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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 17, 2023	
Inspection Number: 2023-1264-0003	
Inspection Type: Complaint	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Trillium Court, Kincardine	
Lead Inspector Helene Desabrais (615)	**Inspector Digital Signature** Helene Desabrais Digitally signed by Helene Desabrais Date: 2023.07.18 09:01:20 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 12, 13, 14, 2023

The following complaint intake was inspected:

- Intake #00088415, related to prevention of abuse and neglect and responsive behaviours.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including, identifying and implementing interventions.

Rational and Summary

The home did not identify and implement interventions specifically to minimize the risk of altercations and potentially harmful interactions between the two residents.

The Director of Care (DOC), the Behavioural Support Ontario Lead (BSO Lead) and a Personal support Worker (PSW) stated that a resident was an identified trigger for the resident and should have implemented interventions to minimize the risks of altercations.

The home's failure to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions caused harm to a resident.

Sources: Complaint submitted to the Ministry of Long-Term Care, the home's Critical Incident, two residents' clinical records, the home's Responsive Behaviours Procedure Policy # CARE3.010.02 (last reviewed March 31, 2023), interviews with a PSW, the BSO Lead and the DOC.

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