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: September 9, 2024
Inspection Number: 2024-1264-0004
Inspection Type: Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Trillium Court, Kincardine

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-30, 2024, and September 3-4, 2024.

The following intake(s) were inspected:

Intake: #00121401 / Intake: #00125036 related to falls prevention and management.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The Licensee failed to update strategies to reduce or mitigate falls, when a resident had multiple previous falls.

Rationale and Summary

A resident was assessed at high-risk for falls and had multiple falls including one with injury.

The home's "Fall Prevention and Injury Reduction Program" last reviewed March 31, 2024, documented when a resident falls, strategies are to be put in place to prevent further falls and reduce risk of fall-related injuries. New strategies for fall prevention or to addressing fall risk had not been completed prior to the resident's fall with injury.

Various staff interviewed provided strategies for fall prevention that may have been effective for the resident. Staff were unable to confirm consistent interventions that were implemented prior to the resident's fall with injury.

Staff stated during previous post-fall assessments for the resident, interventions that have been identified by staff had not been added to their plan of care and should have been.

Sources:

Resident's care plan, the homes Fall Prevention and Injury Reduction Program policy, risk management assessment, interviews with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee failed to implement interventions to mitigate and manage nutritional risks when resident was not provided a modified diet.

Rationale and summary

A resident fell, resulting in transfer to hospital and an injury. Upon return from hospital, the resident was to receive a modified diet.

The resident's progress notes documented that a modified diet had not been provided to the resident. Staff stated that the resident was observed to be in pain

when eating this meal.

Staff stated they were aware that the resident was to have a modified diet upon return from hospital, but was unaware of the process to inform the dietary department. The dietary department was made aware two days later that the resident required a modified diet.

When the home did not ensure that the resident received a modified diet, the resident was observed to be in pain when eating a regular textured meal.

Sources:

Review of the resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The Licensee failed to report to the Director in one business day after an incident that lead to a significant change to a resident's health status.

Rationale and Summary

The home reported an incident that lead to a significant change to a residents health status to the Director three days late.

Staff stated the critical incident was submitted late to the Director.

Sources:

Critical incident report, progress note, and interview with staff.