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: November 22, 2024

Inspection Number: 2024-1264-0006

Inspection Type:
Critical Incident
Follow up

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Trillium Court, Kincardine

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 12-15, and 19-20, 2024

The following intakes were inspected:

- Intake: #00124094 - Follow-up #: 1 - O. Reg. 246/22 - s. 96 (1) (b) Maintenance services.
- Intake: #00124095 - Follow-up #: 1 - O. Reg. 246/22 - s. 20 (f) Communication and response system.
- Intake: #00129723 - CI 2773-000043-24 - Allegation of improper resident care to resident.
- Intake: #00130432 - CI 2773-000045-24 - Unexpected death of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1264-0003 related to O. Reg. 246/22, s. 20 (f).
Order #002 from Inspection #2024-1264-0003 related to O. Reg. 246/22, s. 96 (1) (b).

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 a resident received blood work as ordered by their physician.

Rationale and summary
Regular onsite bloodwork services were available for residents once a week. Nursing staff were responsible for coordinating residents to receive their bloodwork in accordance with physicians' orders.

The home's physician ordered a resident to receive repeat blood work in one week.

It was not completed at that time.

When their blood work was not initiated as ordered by the physician, there was a delay in assessment and treatment for a resident.

Sources: A resident's clinical records; interviews with the home's physician, and other staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to ensure a resident's unexpected death was reported immediately to the Director.

Rationale and summary
A resident passed away from an unexpected illness.

The home's staff and physician reported the resident had previously been at their relative baseline, and their acute symptoms were reported to have arisen overnight, their first occurrence since admission. The home's physician considered the resident's death as unexpected.

The home did not submit a report for the resident's death to the Director in accordance with requirements of Ontario Regulation s. 115 (5) until a week later.

When the home did not immediately inform the Director of a resident's unexpected death in accordance with regulations, the Director was unable to take action, if it had been merited.

Sources: Critical incident reports 2773-000043-24 and 2773-000045-24, interviews with the home's physician and other staff, as well as a resident's clinical records.