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

Public Report

Report Issue Date: January 16, 2025

Inspection Number: 2025-1264-0001

Inspection Type:
Complaint
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): January 6-10 and 14-16, 2025.

The following intake(s) were inspected:

- Intake: #00129190 - unwitnessed fall of a resident.
- Intake: #00129671 - staff-to-resident alleged neglect.
- Intake: #00131552 - staff-to-resident alleged sexual abuse.
- Intake: #00131917 - related to a disease outbreak.
- Intake: #00133126 - related to a staff complaint alleging neglect of residents.
- Intake: #00134063 - related to a complaint regarding staffing issues in the home.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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 has failed to ensure that a resident received their morning care at the time specified in their plan of care. As a result, they would be late for breakfast.

Sources: Record review of meal times, a resident's clinical records; observations of a resident and the posted meal times; and interviews with a resident and Personal Support Worker (PSW).

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from verbal abuse by a Personal Support Worker (PSW).

For the purpose of the definition of "abuse" in subsection 2 (1) of the Act and Regulation, “verbal abuse” means:
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

A resident described two incidents where a PSW communicated in a manner that was belittling and degrading in nature. By failing to protect the resident from verbal abuse, this negatively impacted resident's well-being and dignity.

Sources: Record review of the home's internal investigation notes and interview statements; and interviews with a resident and the Executive Director (ED).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 has failed to immediately report an allegation of neglect of a resident to the Director.

An allegation of neglect to a resident by a Registered Nurse (RN) was submitted by

email correspondence by a staff member to the Director of Care (DOC). The home was required to submit a Critical Incident (CI) Report to the Director immediately, however it was not submitted until a week after the allegation.

Sources: Record review of Critical Incident (CI) Report, and a complaint via email correspondence to the DOC by a staff member; and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that several residents were bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements.

Sources: Resident clinical records; interviews with Personal Support Aide (PSA) and a resident; the Home's investigation notes of the Critical Incident (CI).