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 6, 2023	
Inspection Number: 2023-1246-0003	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Riverbend Place, Cambridge	
Lead Inspector Kaitlyn Puklicz (000685)	**Inspector Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2023.09.07 16:16:08 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29 - 31, 2023 and September 1, 5, 2023.

The following intake(s) were inspected:

- Intake: #00088817 - Alleged staff to resident neglect.
- Intake: #00089420 - Falls prevention and management.

The following intake(s) were completed in this inspection:

Intake #00086676, Intake #00092495, and Intake #00092504 related to falls.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care and bowel management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c) related to continence care.

The licensee has failed to ensure that a resident received the assistance required to manage their continence.

Rationale & Summary

A registered nurse (RN) found a resident, upset and requesting assistance with toileting. The resident required staff assistance to toilet and the RN observed the resident was sitting in a soiled incontinence product. The RN then provided incontinence care and toileting to the resident.

The home's internal investigation notes indicated that staff did not assist the resident to the toilet as required, for over 4 hours, prior to the RN providing assistance to the resident.

The Director of Care (DOC) stated that the resident required staff assistance to toilet and that they reviewed camera footage which was how they determined that the resident was not toileted as required.

Failing to support the resident with the assistance required to manage and maintain their continence put the resident at risk of skin breakdown and emotional distress.

Sources:

Clinical record for the resident, home's internal investigative notes, interview with the DOC.

[000685]