



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

London Service Area Office  
291 King Street, 4th Floor  
LONDON, ON, N6B-1R8  
Telephone: (519) 675-7680  
Facsimile: (519) 675-7685

Bureau régional de services de  
London  
291, rue King, 4<sup>ième</sup> étage  
LONDON, ON, N6B-1R8  
Téléphone: (519) 675-7680  
Télécopieur: (519) 675-7685

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

### **Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 17, 2014	2014_183135_0025	L-000303-14	Critical Incident System

#### **Licensee/Titulaire de permis**

REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

#### **Long-Term Care Home/Foyer de soins de longue durée**

SUMAC LODGE  
1464 BLACKWELL ROAD, SARNIA, ON, N7S-5M4

#### **Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

BONNIE MACDONALD (135)

### **Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): April 15, 2014.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Clinical Lead, Registered Nurse, RAI Coordinator and Registered Practical Nurse.**

**During the course of the inspection, the inspector(s) reviewed resident clinical records and home's incident reports. Observed resident care and services provided in resident home area.**

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



**Critical Incident Response  
Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**



Specifically failed to comply with the following:

**s. 107. (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 (4):**

**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**

**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**

**i. a breakdown or failure of the security system,**

**ii. a breakdown of major equipment or a system in the home,**

**iii. a loss of essential services, or**

**iv. flooding.**

**O. Reg. 79/10, s. 107 (3).**

**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**

**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

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#### **Findings/Faits saillants :**

1. The licensee failed to inform the Director no later than one business day after the occurrence of the incident of:

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

Resident #01 assessed at high risk for elopement was missing from the home for less than 3 hours. Resident was returned to the home with no injury or adverse change of condition.

During an interview, the Administrator confirmed the home had not notified the Director that the resident was missing from the home. The Administrator confirmed, her expectation that the Director be informed no later than one business day of any residents that are missing from the home for less than 3 hours. [s. 107. (3)]



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**Issued on this 17th day of April, 2014**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**