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: August 28, 2023.
Inspection Number: 2023-1133-0003
Inspection Type: Complaint Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Summit Place, Owen Sound
Lead Inspector Katy Harrison (766) — **Inspector Digital Signature** Kathryn Harrison Digitally signed by Kathryn Harrison Date: 2023.08.29 15:15:25 -04'00'
Additional Inspector(s) Tanya Murray (000735)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15-17, 22-24, 2023.
The inspection occurred offsite on the following date(s): August 18, 21, 2023.

The following intake(s) were inspected:

- Intake: #00015040, CI #2624-000020-22 related to skin and wound
- Intake: #00021803, CI #2624-000010-23 related to skin and wound
- Intake: #00084059, CI #2624-000014-23 related to neglect/ improper care
- Intake: #00086657, CI #2624-000017-23 related to sexual abuse
- Intake: #00088040, Complaint related to falls management
- Intake: #00091008, Complaint related to falls management

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

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

Prevention of Abuse and Neglect
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 (2)

The licensee has failed to ensure that a post-fall assessment was completed for a resident.

Rationale and Summary

When a resident fell the home failed to complete a post-fall assessment as required.

The RN and DOC confirmed that the assessment should have been completed for the resident.

Failure to complete a post-fall assessment using a clinically appropriate assessment instrument could have resulted in a negative outcome for the resident.

Sources: Resident progress notes, Risk Management reports, interviews with Registered Nurse (RN) and Director of Care (DOC). [000735]

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) 5.

The licensee has failed to ensure that an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act, was reported to the Director immediately, as required.

Rationale and Summary

The IPAC Lead said the home had been in respiratory outbreak since August 3, 2023. The home was declared to be in respiratory outbreak by Grey Bruce Public Health Unit. The cause of the outbreak was Rhinovirus.

The IPAC Lead said they did not report the outbreak to the Director as they thought only COVID outbreaks were reportable.

By not reporting the incident to the Director immediately, the Director was not able to respond to the concerns of the outbreak if required.

Sources: Critical Incident Report (CIS), dated August 15, 2023, interview with Infection Prevention and Control (IPAC) Lead. [766]