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: June 11, 2025

Inspection Number: 2025-1133-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Summit Place, Owen Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 20-23, 26-30, 2025 and June 2-5, 2025

The inspection occurred offsite on the following date(s): May 22, 2025

The following intake(s) were inspected:

- Intake: #00142700, Complainant regarding alleged abuse and neglect
- Intake: #00143795, Critical incident (CI) # 000021-25: related to allegation of neglect of resident resulting in a fall
- Intake: #00147584, Complaint regarding improper care of a resident
- Intake: #00147972, Complainant regarding allegations of neglect and unsafe transfers
- Intake: #00148225, CI #000036-25: Alleged verbal and physical abuse to a resident
- Intake: #00148268, CI #-000035-25 – Regarding alleged improper care to resident
- Intake: #00148380, CI #-000037-25: Alleged neglect of a resident by a staff member
- Intake: #00148389, CI #-000039-25: Alleged physical and emotional abuse of a resident
- Intake: #00148666, CI #000040-25: regarding an unwitnessed fall of resident

- Intake: #00149009, CI #000043-25: regarding alleged neglect to resident
- Intake: #00149171 -complaint regarding alleged neglect of a resident

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A)The licensee failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to fully participate in the development and implementation of the resident's care plan when their health changed.

The substitute decision-maker (SDM) was informed about changes to the resident's health but not when they further declined and there was changes to the resident's orders to manage that change.

Sources: clinical record of resident, interviews with the Director of Care (DOC) and others

B)The licensee failed to ensure that a resident's SDM requested that a staff member not provide care for the resident, that was honoured when they provided direct care to the resident several more times.

Sources: resident clinical record, interview with the Director of Care (DOC) and others

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that when a resident's mobility status changed, this was reflected in their care plan.

Sources: residents clinical record, interview with Registered Nurse

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints;
(b) ensure that the written procedures include information about how to make a complaint to the patient ombudsman under the Excellent Care for All Act, 2010 and to the Ministry; and
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee failed to ensure their policy for dealing with complaints was followed.

In accordance with Ontario Regulations (O. Reg. 246/22, section 11. (1) (b), the licensee didn't comply with their policy, when they became aware of multiple complaints from the family of a resident and their care and didn't forward the complaints to the Director.

Sources: resident's clinical record, Summit Place complaints binder, complaint policy, interview with the Director of Care.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

The licensee has failed to ensure that appropriate action was taken when they became aware of the allegations of abuse towards a resident by others and the concerns were not immediately investigated.

Sources: Client Services Responses Forms, interview with the DOC and others

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 failed to ensure that when a staff member had reasonable grounds to suspect abuse had occurred to a resident they reported it to the Director. In accordance with LTCA, 2021 s. 154 (3), the licensee as the LTCH is vicariously liable when a staff member fails to report abuse.

Sources: interview with the DOC and others

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee failed to ensure that when a resident fell, a post fall assessment was completed.

Sources: resident's clinical record, interview with the DOC and others

WRITTEN NOTIFICATION: Police Notification

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed

incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that appropriate action was taken when they became aware of the allegations of abuse towards a resident by others and the concerns were not immediately investigated.

Sources: Client Services Responses Forms, interview with the DOC and others

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1)
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and

its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee failed to ensure that the many written and verbal complaints made to the LTCH concerning the care of a resident were dealt with and included investigations, dates, a written response, documentation of the complaint and responses and analysis of trends and the complaints were forwarded to the Director as necessary.

Sources: client Services Responses Form binder, interview with the DOC and others

COMPLIANCE ORDER CO #001 Duty to protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure:

1)A staff member will have the opportunity to review a brief summary of the unsafe transfers they conducted in the last six months. A copy of the summary should be

kept on file and should include, but not be limited to, the date, time, content of the information reviewed and names of the staff who reviewed the summary with the staff member.

2)The staff member will receive immediate re-training on the Resident Non-Abuse program and Safe Lifts and Transfers, facilitated by a qualified trainer at the home. A copy of the training record should be kept on file and should include the date, time, content of the training and names of the staff who provided the training.

3)The staff member shadows a peer for three consecutive shifts (days and/or evenings) within a week to reinforce correct Safe Lifts and Transfers techniques. The plan should include the name of the person responsible for providing the shadowing experience, as well as the dates and shifts worked.

4)The staff member is audited through observed after the shadowing experience to confirm competency before resuming independent transfers. A record should be kept on file that specifies who will be responsible for conducting the audit, the date and time audits were conducted, resident names, staff names, and any corrective actions taken in response to the audit.

5)The staff member writes a summary of the areas of improvement and actions to address sustainability, including outlining how safe practices will be maintained moving forward. This summary should be submitted to their immediate manager and include the date, time.

Grounds
The licensee failed to protect a resident from neglect.

In accordance with O. Reg. 246/22 s. 7, “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the

health, safety or well-being of one or more residents.

The resident was provided with care and left in an unsafe location without safety measures in place.

The resident fell and sustained injuries.

Failure to review and follow the resident's plan of care for safety measures and leaving the resident in an unsafe situation placed the resident's health, safety and well-being at high risk of harm.

Sources: Critical incident System (CIS) # 2624-000021-25, clinical record of the resident, interviews with a PSW

This order must be complied with by June 30, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.