Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
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130, avenue Dufferin 4ème étage
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 14, 2021	2021_729615_0023	004394-21, 005391-21, 006281-21, 007354-21, 007359-21, 007681-21, 009097-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

HELENE DESABRAIS (615), DEBRA CHURCHER (670)

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): July 5, 6, 7, and 8, 2021.

The following intakes were inspected during this inspection:

Log #005391-21/Critical Incident System (CIS) report #2573-000011-21, related to falls prevention;
Log #004394-21/CIS #2573-000008-21; Log #006281-21/CIS #2573-000013-21; Log #007354-21/CIS #2573-000016-21; Log #007359-21/CIS #2573-000017-21; Log #007681-21/CIS #2573-000018-21 and, Log #009097-21/CIS #2573-000021-21, related to prevention of abuse, neglect and retaliation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, the Infection Control Manager, the Registered Practical Nurse - Behavioural Support Ontario Lead, a Registered Nurse, a Registered Practical Nurse, a Personal Support Worker, a Housekeeping staff and five residents.

The inspectors also observed resident rooms and common areas, observed Infection Prevention and Control practices and the cooling systems within the home, observed residents and the care provided to them, reviewed clinical records and plans of care for identified residents, reviewed Critical Incident System (CIS) reports, reviewed the home's internal investigation reports and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that two residents were protected from sexual abuse by a resident.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as “any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member”.

On a specific date, the home submitted a Critical Incident System (CIS) report related to resident to resident alleged sexual abuse and that the one resident was afraid of them. The resident had interventions in place at the time. During a record review of a resident’s progress notes in Point Click Care, incidents of sexual abuse took place 13 times on different dates. A review of a resident’s care plan at the time of the incidents indicated a history of sexual abuse towards other residents.

During an interview with a Registered Practical Nurse-Behavioral Support Ontario Lead (RPN-BSO), they stated they did not understand why the resident was left alone with residents and why inappropriate touching was still occurring despite having intervention in place. The RPN-BSO acknowledged that the resident was often left alone and this was when they would inappropriately touch residents and that the resident was specifically targeting a resident. They stated a better job should have been done to protect residents.

During an interview, the Director of Care (DOC) stated that monitoring of the resident was scheduled around the clock during five days during these incidents for the resident’s sexual behaviours, and acknowledged they did not know how the resident could still inappropriately touch residents. DOC added that the resident was fixated with a resident and maybe should of have moved them to another area of the home.

The failure to ensure residents' safety from a resident caused the residents actual harm.

Sources: CIS, a resident's clinical records and interview with staff.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of residents by anyone or neglect of a resident had occurred by the licensee or staff that resulted in harm or a risk of harm to the residents immediately reported the suspicion and the information to the Director. Pursuant to s.152 (2), the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A review was conducted of an email sent on a specific date by Personal Support Worker (PSW) to the Director of Care (DOC) and then forwarded by DOC to a Nurse Manager (NM) minutes later. Within the email, the PSW alleged neglect and abuse towards residents. A review of two Critical Incident System (CIS) reports related to alleged abuse and neglect of a resident was submitted two days after the incident. A review of a CIS related to alleged abuse and neglect of a resident was submitted eight days after the incident. A review was conducted of an email sent on a specific date by a Staff Support Aide (SSA) to the DOC. Within the email the SSA referenced a conversation that was held with the DOC during that date related to the allegations of abuse and neglect that they were bringing forward that occurred seven to eight days prior.

During an interview the DOC stated that both the PSW and the SSA should have reported any suspicions of abuse and neglect immediately and did not. The DOC also acknowledged that the three CISs of alleged abuse were not reported immediately.

Failure to report suspected abuse of neglect of residents within the required time frames placed the residents at risk of harm.

Sources: Three CISs, the home’s internal investigation notes, emails and interview with the DOC.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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: 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, to be implemented voluntarily.

Issued on this 14th day of July, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	HELENE DESABRAIS (615), DEBRA CHURCHER (670)
Inspection No. / No de l’inspection :	2021_729615_0023
Log No. / No de registre :	004394-21, 005391-21, 006281-21, 007354-21, 007359-21, 007681-21, 009097-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 14, 2021
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Sumac Lodge 1464 Blackwell Road, Sarnia, ON, N7S-5M4
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Matthew Summerfield

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19 of the LTCHA.

Specifically, the licensee must:

-Re-educate all staff on recognizing abuse and follow residents' plan of care to ensure their safety, and;
-Document the education, including the date and the staff member who provided the education.

Grounds / Motifs :

1. The licensee failed to ensure that two residents were protected from sexual abuse by a resident.

Section 2 (1) of the Ontario Regulation 79/10 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

On a specific date, the home submitted a Critical Incident System (CIS) report related to resident to resident alleged sexual abuse and that the one resident was afraid of them. The resident had interventions in place at the time. During a record review of a resident's progress notes in Point Click Care, incidents of sexual abuse took place 13 times on different dates. A review of a resident's care plan at the time of the incidents indicated a history of sexual abuse towards other residents.

During an interview with a Registered Practical Nurse-Behavioral Support

Ontario Lead (RPN-BSO), they stated they did not understand why the resident was left alone with residents and why inappropriate touching was still occurring despite having intervention in place. The RPN-BSO acknowledged that the resident was often left alone and this was when they would inappropriately touch residents and that the resident was specifically targeting a resident. They stated a better job should have been done to protect residents.

During an interview, the Director of Care (DOC) stated that monitoring of the resident was scheduled around the clock during five days during these incidents for the resident's sexual behaviours, and acknowledged they did not know how the resident could still inappropriately touch residents. DOC added that the resident was fixated with a resident and maybe should of have moved them to another area of the home.

The failure to ensure residents' safety from a resident caused the residents actual harm.

Sources: CIS, a resident's clinical records and interview with staff.

An order was made by taking the following factors into account:

Severity: this non-compliance was found to have a severity of actual harm to the residents.
Scope: the scope was isolated as it was found with few residents in the home.
Compliance history: the home had no previous history of non-compliance in this area. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Helene Desabrais

Service Area Office /
Bureau régional de services : London Service Area Office