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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 23, 2023
Inspection Number: 2023-1089-0004
Inspection Type: Follow up Critical Incident System
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Sumac Lodge, Sarnia

Lead Inspector	**Inspector Digital Signature**
Stacey Sullo (000750)	Stacey Sullo Digitally signed by Stacey Sullo Date: 2023.08.23 10:11:12 -04'00'

Additional Inspector(s)
Debra Churcher (670)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 15, 16, 2023

The following intake(s) were inspected:

- Intake: #00088944 - Follow-up #: 1 - O. Reg. 246/22 - s. 140 (2)
- Intake: #00092917 - Related to a fall with injury
- Intake #00087998. This intake was reviewed on August 14, 2023 with other other intakes related to falls prevention. The program issue was inspected August 14, 15 and 16th, 2023, under inspection # 2023-1089-0004, intake # 00092917, with the following non-compliance identified: NCR was issued for s.6 (1) (c) under FLTCA, 2021.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1089-0003 related to O. Reg. 246/22, s. 140 (2) inspected by Stacey Sullo (000750)

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

Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff.

Rationale and Summary:
Review of a resident's written plan of care showed no reference to the resident's specific care need and need for assistance.

During interviews with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) they stated that the resident required the use of specific equipment and staff assist for their care need.

During an interview with the Director of Care (DOC) they acknowledged that the plan of care did not provide clear direction to the staff.

Review of a resident's written plan of care and interview with the DOC showed that the plan of care had been updated to provide clear direction to staff.

Sources:
A resident's clinical record and, interviews with a PSW, RPN and the DOC.
[000750]

Date Remedy Implemented: August 16, 2023