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
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Original Public Report

Report Issue Date: January 26, 2023
Inspection Number: 2023-1089-0001
Inspection Type: Complaint Critical Incident System
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Sumac Lodge, Sarnia

Lead Inspector	**Inspector Digital Signature**
Debra Churcher (670	Debra Churcher Digitally signed by Debra Churcher Date: 2023.02.01 09:02:08 -05'00'

Additional Inspector(s)
Ina Reynolds (524)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 16, 17, 18, and 19, 2023.

The following intake(s) were inspected:

- Intake: #00001646-[CI: 2573-000012-22] related to an injury of unknown origin.
- Intake: #00008788 [CI:2573-000018-22] related to alleged staff to resident abuse.
- Intake: #00011591-IL-06513-LO/IL-06834-LO - Complainant related to transferring and positioning techniques, reports regarding critical incidents, abuse, care conference, nutrition and hydration and plan of care.
- Intake: #00015808 [CI:2573-000029-22] related to a fall with injury.
- The following intakes were completed in this inspection: Intake #00005050, CI#2573-000009-22 and Intake #00014381, CI# 2573-000024-22 were related to falls with injury.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a specific resident from abuse by a specific staff member.

The home submitted Critical Incident System report (CIS) on a specific date, reporting alleged abuse of the resident by a staff member. Complaints were submitted to the Ministry of Long-Term Care on two specific dates alleging abuse.

During an interview with the resident they stated that a specific staff member had been abusive to them and that they continued to feel afraid when they saw the identified staff member.

During an interview with the identified staff member they acknowledged that they had been abusive to the resident and had “snapped”.

Sources: CIS, interviews with the resident and the identified staff member.

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WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred should have immediately reported the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The Ministry of Long-Term Care received complaints on two separate dates with concerns related to a resident being injured during a care task.

Review of the specific resident's progress notes and assessment notes, for a specific date showed that the resident had received an injury during the provision of a specific care task.

During an interview with the resident they recalled the incident and how the injury occurred.

This Inspector was unable to locate a Critical Incident System report (CIS).

During an interview with Manager of Resident Care (MRC) they stated that the previous Director of Care had been looking into the incident and that a CIS should have been submitted.

Sources: The resident's clinical record, review of the CIS system and interviews with the resident and MRC.
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WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance of Abuse

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that their Resident Non-Abuse Program policy was complied with.

The home's policy titled Resident Non-Abuse Program, last reviewed March 31, 2022, stated "The priority is to ensure the safety and comfort of the abuse victims by taking steps to provide for their immediate safety and well being, then completed full assessments to determine the Resident's needs and document them on the Resident's plan of care."

The home submitted Critical Incident System report (CIS) on a specific date, reporting alleged abuse of the resident by a staff member. Complaints were submitted to the Ministry of Long-Term Care on two specific dates alleging abuse.

This Inspector was unable to locate any documentation related to additional supports offered to the resident post incident.

During an interview with the resident they stated that a specific staff member had been abusive to them and that they continued to feel afraid when they saw the identified staff member.

During an interview with the Manager of Resident Care (MRC) they stated that it had been established that a specific staff member had been abusive to the resident and that they were not aware of any additional supports offered to the resident after the incident.

Sources: CIS, review of the resident's clinical records, interview with MRC and the resident.
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WRITTEN NOTIFICATION: Nutrition and Hydration Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to ensure that a specific resident was weighed monthly.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter, and must be complied with.

During a review of the resident's clinical record this inspector was unable to locate any resident weights for two specific months.

During an interview with the Manager of Resident Care (MRC) they shared that the process in the home was the Personal Support Worker (PSW) completing the baths would write the weight on the bath sheet and the weight would be transcribed into the home's electronic documentation system.

The MRC confirmed that they were unable to find weights for the resident for the two specific months.

Sources: The resident's clinical record and interview with the MRC.
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