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
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London, ON, N6A 5R2
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Public Report

Report Issue Date: February 7, 2025

Inspection Number: 2025-1089-0001

Inspection Type:
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Sumac Lodge, Sarnia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3, 4, 5, 6, 7, 2025

The following intake(s) were inspected:

- Intake: #00133094 - 2573-000041-24 - related to Infection Prevention and Control
- Intake: #00134535 - 2573-000044-24 -related to alleged neglect of a resident
- Intake: #00137840 - 2573-000002-25 - related to Infection Prevention and Control
- Intake: #00138266 - 2573-000003-25 - related to Infection Prevention and Control
- Intake: #00138736 - IL-0136436-AH/2573-000004-25 - related to alleged neglect of a resident

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Late Reporting

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee failed to immediately report alleged neglect of a resident to the Director. An incident described in a Critical Incident Report was not reported for many days after the incident had occurred.

Sources: interview and Critical Incident Report.

WRITTEN NOTIFICATION: Door Lock

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

The licensee failed to ensure that a door which lead to a secure outside area, was equipped with a lock to restrict unsupervised access to that area by a resident. The door was fully locked from the outside but not from the inside. A resident used this exit to access the courtyard and was not able to re-enter the facility for a short period of time until a staff member discovered them. There was risk of harm to the resident when they were not able to re-enter the home.

Sources: observation of door, interview, and investigation notes.