Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 22, 2024	
Inspection Number: 2024-1133-0001	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Summit Place, Owen Sound	
Lead Inspector Dianne Tone (000686)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22- 26, 29, 2024
The inspection occurred offsite on the following date(s): January 30-31, 2024 and February 1, 2024

The following intake(s) were inspected:

- Intake: #00098437 - Infection Prevention and Control
- Intake: #00104756 - Duty to Protect/Late reporting

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control

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Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 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 has failed to ensure that an allegation of neglect was immediately reported.

Rationale and Summary:
The home reported an allegation of neglect, late, to the Director.

Interim DOC and RN confirmed that the allegation of neglect should have been reported immediately.

When the allegation of neglect was not immediately reported, the home and Director were not able to respond to the incident in a timely manner.

Sources: Interview with Interim DOC, RN, Review of Critical Incident, and home's investigation notes.
[000686]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure safe transferring techniques were used when assisting a resident with a mechanical lift.

Rational and summary
A) The home's Safe Resident Handling policy stated that two staff must be present at all times while the mechanical device is in operation.

A PSW stated they transferred a resident using a mechanical lift without the assistance of another staff member.

When residents are transferred without the appropriate number of staff present, they are at risk of injury.

Sources: Transfer Status Assessment Guide Policy, Interviews with an RN and PSW.
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The Licensee has failed to ensure that proper positioning techniques were used when resident was positioned in bed.

Rational and Summary
B) A resident was transferred to bed in the evening and their bed was left in an unsafe location resulting in an injury.

The home's investigation determined that the bed position was unsafe and contributed to a resident sustaining an injury.

Sources: Resident clinical record, Confidential Investigation Report, Interviews with Interim DOC, PSW, email correspondence Acting ED.

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