



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des Soins  
de longue durée**

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

**Rapport d'inspection prévue  
sous la Loi de 2007 sur les foyers  
de soins de longue durée**

**Long-Term Care Homes Division  
Long-Term Care Inspections Branch**

**Division des foyers de soins de  
longue durée  
Inspection de soins de longue durée**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130 avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du public**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Mar 25, 2019	2019_563670_0010	003978-19	Complaint

---

**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**

DEBRA CHURCHER (670)

---

**Inspection Summary/Résumé de l'inspection**

---



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des Soins  
de longue durée**

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

**Rapport d'inspection prévue  
sous *la Loi de 2007 sur les foyers  
de soins de longue durée***

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): March 19 and 20, 2019**

**The following complaint was inspected during this inspection:  
Log# 003978-19 IL-64445-LO related to concerns with fall prevention.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, one Nurse Manager, two Registered Nurses and one Personal Support Worker.**

**During the course of this inspection the inspector observed the overall cleanliness and maintenance of the home, completed relevant record review, completed relevant interviews and completed relevant observations of residents and the provision of care.**

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

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

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**



1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint IL-64445-LO was received by the Ministry of Health and Long-Term Care on a specific date.

Review of resident #001's clinical record showed that the resident experienced an incident on a specific date.

Resident #001's current care plan stated the resident was to be using a specific personal assistive service device (PASD) to remind the resident not to perform an action without assistance.

On March 19, 2019, resident #001 was observed on three separate occasions without the PASD in place.

During an interview resident #001 stated that they never used the PASD

During an interview Registered Nurse (RN) #102 stated that the use of the specific PASD was one of the interventions in place for resident #001.

During an interview RN #103 they stated that resident #001 should be using the PASD when they are not in bed.

During an interview Personal Support Worker (PSW) #104 stated that the PASD was a safety intervention for resident #001.

Executive Director #101 acknowledged that resident #001 should have had the PASD in place.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]



Ministry of Health and  
Long-Term Care

Ministère de la Santé et des Soins  
de longue durée

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

Rapport d'inspection prévue  
sous *la Loi de 2007 sur les foyers  
de soins de longue durée*

***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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

---

Issued on this 25th day of March, 2019

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

**Original report signed by the inspector.**