RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: May 29, 2014	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: Revera Long Term Care Inc. / 55 Standish Court, 8th Floor, Mississauga, ON L5R 4B2 (the "Licensee")	
Retirement Home: Brierwood Gardens / 425 Park Road N., Brantford, ON N3R 7G5 (the "home")	
Licence Number: S0178	

Purpose of Inspection
The RHRA received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance of abuse. Specifically, the Licensee failed to comply with the following subsection: **s. 67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.
Inspection Finding The home failed to follow its policy to promote zero tolerance of abuse by: 1. The home did not report an incident regarding two residents immediately to the RHRA. The incident occurred on May 5, 2014 and was reported to the RHRA on May 20, 2014. 2. The home did not notify one of the residents involved of the results of the investigation.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan. Specifically, the Licensee failed to comply with the following subsection: **s. 62. (4)** The licensee if a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including, (i) the details of the service (ii) the goals that the services are intended to achieve, and (iii) clear directions to the licensee's staff who provide direct care to the resident.
Inspection Finding The home failed to ensure that the plan of care for one of the residents addressed her vomiting, including the details of how to address the vomiting, the goals that staff intend to achieve, and clear directions to staff that provide direct care to the resident related to her vomiting.
Outcome Corrective action taken by the Licensee.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (the "RHRA") and the home's Residents' Council, if any.

Section 55 of the RHA requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Public Register, available online at http://rhra.ca/en/register/.

Signature of Inspector	Date
	July 17, 2014