RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 20, 2016	**Name of Inspector:** Julie Hebert
Inspection Type: Mandatory Reporting Inspection	
Licensee: Revera Long Term Care Inc. / 55 Standish Court, Mississauga, ON L5R 4B2 (the "Licensee")	
Retirement Home: Blenheim Community Village / 10 Mary Avenue, Blenheim, ON N0P 1A0 (the "home")	
Licence Number: S0184	

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. 65; Training. Specifically, the Licensee failed to comply with the following subsection(s): **65. (2)** Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in, (b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
Inspection Finding The home failed to complete annual training with an employee involved in an incident of resident to resident abuse, resulting in the employee not following proper procedure regarding the Zero Tolerance of Abuse policy.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.** Specifically, the Licensee failed to comply with the following subsection(s): **62. (9)** The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

(c) the care services set out in the plan have not been effective.

Inspection Finding

The plan of care for a resident involved in a resident to resident abuse allegation, had not been approved by the resident or their substitute decision maker. Furthermore, the care plan had not been revised as the resident's care needs changed.

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
Julie Hebert	February 5, 2016