

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

Inspection Information	
Date of Inspection: March 24, 2017	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: Village on the Ridge / 9 Myrtle Street, Ridgetown, ON N0P 2C0 (the "home")	
Licence Number: S0181	

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

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,</p> <p style="padding-left: 40px;">(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;</p>
<p>Inspection Finding</p> <p>Following an incident of resident to resident physical abuse, the home did not follow the policy regarding monitoring the resident and enlisting assistance from outside agencies.</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,</p> <p style="padding-left: 40px;">(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;</p>

- (b) the planned care services for the resident that the licensee will provide, including,
 - (i) the details of the services,
 - (iii) clear directions to the licensee’s staff who provide direct care to the resident;

Inspection Finding

The plans of care for the residents involved in the incident did not include provisions of which care services the home was to be providing for the residents, nor did it include clear directions for staff as to how to provide this care.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.

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 did not follow their abuse policy by completing an immediate investigation, nor fully complete the investigation as per their policy for an incident of resident to resident abuse.

Outcome


The Licensee submitted a plan to achieve compliance by May 5, 2017. RHRA to confirm compliance by inspection.

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 April 26, 2017
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