Ontario

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

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

London District
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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: October 6, 2023	
Inspection Number: 2023-1194-0002	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Blenheim Community Village, Blenheim	
Lead Inspector Cassandra Taylor (725)	**Inspector Digital Signature** Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2023.10.06 13:18:44 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3-4, 2023

The following intake(s) were inspected:

- Intake: #00090214 - Critical Incident (CI) #2695-000011-23 relating to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

Resident #001's Power of Attorney (POA) had requested a specific preference for the resident's room. During observations, the preference was not in place.

During an interview with Assistant Director of Care (ADOC) they indicated the preference was not in place due to a change in the residents' care needs.

The ADOC confirmed that the outdated direction had been removed and the plan of care was revised to reflect the residents' current needs.

Sources: Resident records, observations and staff interview with ADOC.
[725]

Date Remedy Implemented: October 4, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure a falls prevention intervention was in place for a resident.

Rationale and Summary
A resident was identified as being at high risk for falls. An intervention for falls prevention was noted within the resident's care plan.

During an observation, the resident was observed without the intervention.

A registered staff member attended the resident's room with the Inspector and confirmed the resident

did not have the intervention in place and should have.

The ADOC indicated the expectation would have been for staff to ensure all interventions were in place as required.

Sources: Resident records, observations and staff interviews.
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