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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: January 8, 2025
Inspection Number: 2025-1194-0001
Inspection Type: Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Blenheim Community Village, Blenheim

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6- 8, 2025

The following intake(s) were inspected:

- Intake: #00135418 -2695-000032-24 - Unexpected death of resident, secondary to a fall.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
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.

A. The licensee has failed to ensure that the resident's care, as set out in the plan of care, was provided to the resident.
Specifically, a Personal Support Worker failed to ensure that another staff member was present during re-positioning the resident in bed and the resident sustained a fall.

B. The licensee has failed to ensure that resident's care, as set out in the plan of care, was provided to the resident.
Specifically, the interventions specified in the fall prevention care plan were not applied to this resident prior to resident's fall.

Sources: resident's clinical record and interview with staff.

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