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: April 30, 2025

Inspection Number: 2025-1194-0002

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): March 4, 5, 6, 11, 12, 17, 20, 2025 and April 22, 2025

The following intake(s) were inspected:

- Intake: #00137633 - Respiratory Outbreak
- Intake: #00140516 - Allegations of abuse and neglect to resident's by staff

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect residents from abuse and neglect by anyone.

Ontario Regulation 246/22, s. 2(1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain; and verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Pursuant to O. Reg. 246/22, s. 7, For the purposes of the Act and this Regulation, “neglect” means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

On February 21, 2025, the home submitted a Critical Incident (CI) to the Ministry of Long-Term Care (MLTC) reporting allegations of neglect and abuse to residents by staff member.

Review of the home's Investigation forms completed by staff confirmed several staff had witnessed abuse and neglect to residents by a staff member.

On April 22, 2025, the home confirmed the allegations of abuse and neglect had occurred to residents by a staff member.

Sources: Resident observations, interviews with staff members and resident, record review of the home's investigation forms, critical incident report, and the abuse policy.

COMPLIANCE ORDER CO #001 Reporting certain matters to Director

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 28 (1) 2
The licensee shall:
1) Provide retraining to all registered staff, personal support workers including agency staff who provide care to residents #001, #002, #003, #004, #005, #007, #008, on the midnight shift on:
The definition of physical, verbal, and emotional abuse including neglect.
The duty to report under section 28 (1) of the Fixing Long-Term Care Act, 2021.
How to report when management are not in the building.
2) Keep documented records of the education provided, including the education content, the name of the educator, the names of the attendees, dates of the training, including attendees' signatures and any corrective action taken and by whom.

These documents will be available upon inspector's request.
3) Create a process to ensure sustainability of responsibilities for reporting certain matters to the Director once the home has been successful with all the retraining of staff as mentioned in (#1).

Grounds
The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse or neglect of residents by anyone that resulted in harm or a risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

Rationale and Summary
During the homes investigation staff reported that they never reported witnessing various forms of abuse and neglect to residents at the time of incidents.
Staff confirmed residents involved were moderately to severely cognitively impaired and were unable to recall the incidents.

Record review of the home's investigation forms completed with staff members who confirmed they had witnessed abuse to residents by a staff member, however never reported it. This led to potential repeated incidents without intervention.

Critical Incident (CI) 2695-000005-25, submitted by the home on February 21, 2025, to the Ministry of Long-Term Care reported allegations of abuse to residents by staff member.

Sources: Critical Incident report, interviews with staff, and record review.

This order must be complied with by May 30, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.